PUSHED ORGANIZATIONAL PULLS

Changing responsibilities, roles and relations of Dutch health care executives

Mirko Noordegraaf, Pauline Meurs & Annemiek Montijn-Stoopendaal

Abstract

This article presents empirical data on organizational reform in Dutch health care, and explores managerial work and behaviour. Two main questions will be answered. First, what organizational reforms are taking place, and how widespread are these reforms? Second, what do reforms mean for the real-life workings of health care organizations, most specifically for managerial behaviour? As far as reforms are concerned, it will be concluded that organizational changes are widespread, especially strategic apex reform and mergers. To a lesser extent, organizational structures are adapted and new relations between management and professionals are developed. Organizational and managerial contexts count albeit in unexpected ways. The professional context counts: management uses organizational reform to provide counterweight vis-à-vis and control of professionals. In addition, managerial background counts, but in a limited way: executives with limited managerial careers opt for organizational reform. Finally, organizational size counts, exerting a strong influence on organizational reform. As far as behavioural consequences are concerned, it will be concluded that organizational reform goes hand-in-hand with behavioural confusion. An 'organizational pull' appears to be strong. Executives are forced to be 'down to earth' managers, while they express 'exotic' desires to be strategists and entrepreneurs. Paradoxically, most organizational reforms strengthen this pull.

Key words

Health care, managerial behaviour, managers/executives, organizational (re)form

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INTRODUCTION

In this article we will explore the relation between new organizational forms in health care and the managerial behaviour of health care executives. First, we will describe which new *organizational forms* were introduced in Dutch health care over the past few years to rationalize and professionalize health care management and to make health care organizations more client-based. We will also explore where such forms were introduced, in what organizational and managerial *contexts*, in order to what reforms have been introduced, why, where and when. Second, we will investigate whether new organizational forms go hand-in-hand with modernized *managerial behaviour* – whether new forms, as might be hypothesized, go hand-in-hand with new responsibilities, roles and relations. We will do this by analysing the outcomes of a questionnaire that was sent to 900 and returned by 450 Dutch health care executives, working in different sorts of health care organizations.

The article is structured as follows. We will provide a general overview of management reform in Dutch health care and we will analyse reform consequences for managerial behaviour (section 2). We will highlight the scarcity of empirical research on health care reform and managerial behaviour, and we will explain how we set up research in order to gather empirical data (section 3). We will then present empirical data (sections 4 and 5). Finally we will draw conclusions (section 6).

MANAGEMENT REFORM IN HEALTH CARE

In The Netherlands, like in many other western countries, the field of health care has witnessed a managerial 'revolution'. Dutch health care institutions have been 'reorganized', 'restructured' and 'reinvented', in order to cope with new demands, constraints and choices. The historical roots can be traced back to 1983, when institutions like hospitals became legally responsible for matching supply and demand, but it was mainly in the 1990s that the reform movement started to make real progress. The movement has much in common with the so-called 'new public management' movement (Hood 1991; Pollitt 1993; Ferlie *et al*. 1996; Kickert 1997; Noordegraaf 2004) that transformed the public sector. It attempted to turn public service provision into a less governmental and more *business-like* and *market-based* affair.

Although Dutch health care services are private not-for-profit organizations, they are strongly embedded in the public sector and thus influenced by changes in public policy and management. The 'managerial' transformation in health care is characterized by, at least, three core features: *rational, client-oriented* and *professional* management. These features are not unique. Comparative research has shown that the same features have spread throughout health care systems in western countries (e.g. Herzlinger 1997; Flood 2000; Busse *et al*. 2002; EOHCS 2002). They are summarized in Table 1.

Table 1: Managerial movements in health care

Rational management	*Client-oriented management*	*Professional management*
Planning and control, management teams, TQM, evidence based management, mergers, ICT, etc.	From functions to process, BPR, product–market combinations, customer groups, entrepreneurship	Management development (MD), masterclasses, managers, medical managers, weakening medical professionalism

First, the management of production processes has been *rationalized*. Health care must be delivered as effectively, efficiently, smoothly and transparently as possible. ‘Planning and control’ systems have been introduced, ‘management teams’ have been formed and new budgetary procedures have been realized. ‘Total quality management’ and ‘evidence-based management’ have gained popularity, in order to strengthen the quality of services and the effectiveness of managerial behaviour. ‘Diagnosis–treatment combinations’ (diagnosis-related groups, DRG) are introduced, so that more effective budgetary decisions can be made, and ‘strategic plans’ are made in order to operate more pro-actively. New information systems have been introduced in order to support all of these attempts to rationalize production.

Second, *patients* and *clients* have become the central focus of attention. Demand-based management has replaced supply-based management, at least in a rhetorical sense. Throughout health care, this stimulated the spread of new organizational forms, which are client- and market-based. Traditional bureaucratic or functional structures have been abolished, and new structures have been created, so that clients no longer experience organizational barriers. Cure and care organizations have been linked and network-like arrangements have been created to ease patient flows. Diseases are used as a starting point for structuring organizations, instead of organizational units like outpatient and clinical departments, which has much in common with ‘business process redesign’ (BPR; Hammer and Champy 1993). In a more systemic sense, the health sector has partly been transformed into a ‘quasi-market’ (cf. LeGrand 2001), with purchaser–provider splits, ‘managed competition’ and patient autonomy.

Third, health care management is slowly being *professionalized*. Health care ‘management’ has evolved into a separate domain and ‘managers’ have been appointed, frequently coming from outside health care. New management positions have been created that link control and cure (after Mintzberg 1997), most specifically ‘medical managers’. In order to select and educate managers, management development programmes have been introduced; Masterclasses are being organized. Last but not least, ‘professional’ associations of health care executives (in The Netherlands, the Dutch Association of Health Care Executives) have become more active. Such associations try to become a ‘regulatory force’ when it comes to professional managerial behaviour. At the same time, there have been pressures to weaken the professional autonomy of doctors (see, for example, Pollitt and Harrison 1994).

These management reforms, which mainly deal with formal organizational procedures, positions, systems and structures, in short *organizational forms*, have obvious but ambiguous consequences for managerial work. New organizational forms are introduced so that managers take on new responsibilities, perform new roles and establish new relations. The nature of these new responsibilities, roles and relations is far from clear, however. First, business-like and market models might be considered to be contradictory, as others have argued before (e.g. Aucoin 1990; Clarke and Newman 1994). On the one hand, they strengthen bureaucratic structures, with rational, top–down control; on the other hand, they deconstruct bureaucratic structures, with empowerment and autonomy. Second, business-like and market models might be at odds with demands and constraints in health care, so that it proves difficult to manage in business-like ways (cf. LeGrand 2001). This might also be interpreted in a normative sense: it can be argued that the business-like model should be treated with care when health care or other public domains are reformed (Pollitt 1993; Noordegraaf 2000).

When it is attempted to summarize the intended reform consequences for managerial work, the following rough picture can be established. As far as *responsibilities* are concerned, modern managers must act 'strategically'. They must not only 'run' and adapt health care organizations efficiently, but also seek strategic opportunities and safeguard continuity. As far as *roles* are concerned, modern managers must act in 'entrepreneurial' ways. They must perform roles that focus on outputs, innovations and quality. As far as *relations* are concerned, modern managers must establish 'external' relations. They must open up their organizations and seek new ways of relating to the outside world.

RESEARCH ON REFORM

The aforementioned organizational forms are attractive, due to their simplicity. They appear to offer grip in turbulent and chaotic times, due to their clear, crisp and consistent imagery (Noordegraaf 2000). New responsibilities, roles and relations appear attractive as well, due to their rejection of 'traditional' managerial behaviour and the remodelling of managerial work, based upon present-day 'heroes', namely entrepreneurs and executives.

To a large extent, most of this might be a matter of seductive *rhetoric* and must be handled with care. As argued, the ideas might be internally contradictory, they might clash with real-life claims, conditions and constraints, and they might be normatively dubious. In other words, it is unclear what *really* happens. It is unclear how organizational forms are modernized; it is unclear which forms are introduced, where and when; it is unclear why changes are introduced, under what conditions; it is unclear if and how modernized forms and real-life behaviour are related. Empirical evidence, at least in The Netherlands, is anecdotal and not really systematic. When empirical evidence is available, for instance on the nature of health care reform (like

Herzlinger 1997; Flood 2000; Busse *et al.* 2002; EOHCS 2002), we lack *specific* evidence on where what reforms are taking place, and what these reforms mean in behavioural terms. To be more systematic, we lack empirical data that allow us to answer three questions:

(1) What specific *changes* in organizational forms are introduced? What types of changes, which new organizational forms, can be identified?
(2) How *widespread* are changes in organizational forms? Who have introduced which new organizational forms, where and when?
(3) What does this mean for the *real-life workings* of health care institutions? What relations can be identified between organizational forms and real-life behaviour? More specifically, what new responsibilities, roles and relations are realized?

Conceptual framework

In this article we will focus on each of these questions, from the perspective of health care managers. We will use the notion of *managerial behaviour* to provide empirical answers, as it enables us to describe changes in organizational forms. This is especially relevant for the latter two questions. We can describe which managers have introduced changes, where and when. For managers have different backgrounds, and some backgrounds are more likely to give rise to organizational reform. We can investigate whether new forms are introduced in specific organizational contexts, with specific managers. For some organizational contexts are more likely to stimulate organizational reform. We can also investigate whether modernized forms go hand-in-hand with 'appropriate' behaviour. For some forms are more likely to require distinctive responsibilities, roles and relations. In conceptual terms, this means we do not seek to explain organizational reform and managerial behaviour in clear causal terms. We attempt to explore correlations among three types of variables, which seem to be crucial for understanding the *causes, characteristics* and *consequences* of health care reform: *organizational reform* (types of organizational forms), *organizational context* (type of organization and organizational size), and *managerial context*, including managerial background and *managerial behaviour* (managers' responsibilities, roles and relations). The conceptual scheme that guides empirical analyses is depicted in Figure 1.

When we use this conceptual scheme against the background of management reform in health care, several hypotheses can be formulated in order to guide empirical research on causes, characteristics and consequences of reform. These hypotheses can be clustered in terms of context and behaviour. As far as context is concerned, we might expect reforms to happen more frequently when certain conditions for rational, client-oriented and professional management are present:

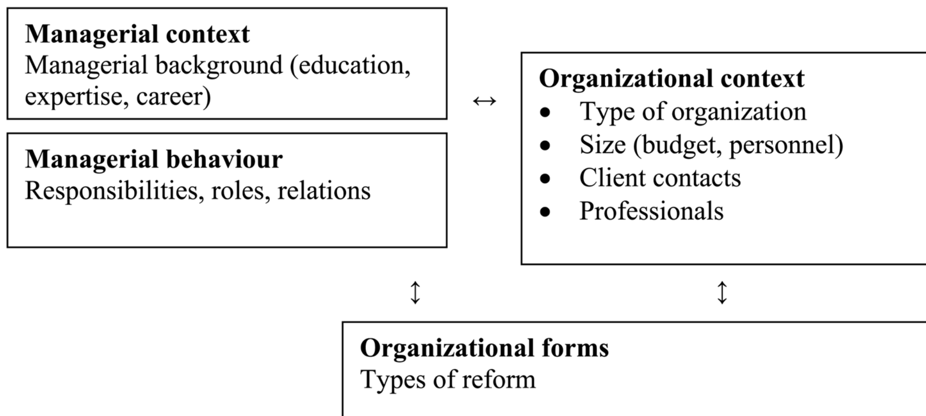

Figure 1: Conceptual scheme

- *Hypothesis 1*: Managers with 'managerial' backgrounds will be more likely to rationalize organizational forms.
- *Hypothesis 2*: Organizations with many clients and high client turnover are more likely to introduce client-based organizational forms.
- *Hypothesis 3*: Organizations with many professionals are more likely to professionalize organizational management.

As far as behaviour is concerned, we might expect health care managers to behave in a more 'business-like' way, which includes the following responsibilities, roles and relations:

- *Hypothesis 4*: Modernized organizational forms will go hand-in-hand with strategic responsibilities.
- *Hypothesis 5*: Modernized organizational forms will go hand-in-hand with entrepreneurial roles.
- *Hypothesis 6*: Modernized organizational forms will go hand-in-hand with external relations.

Methodology

We will open up the black box of organizational (re)form by focusing on health care managers, more specifically high-ranking health care *executives* who are part of strategic apexes of health care organizations (cf. Mintzberg 1983). There are good reasons for doing so. They carry distinctive 'overall' responsibilities for strengthening and improving health care organizations, and their behaviour has reciprocal qualities. They

initiate organizational reform *and* are affected by organizational reform. This enables us to apply the aforementioned conceptual framework and to test reform hypotheses.

We will test the aforementioned six hypotheses by analysing the outcomes of a large-scale *survey*, belonging to the first phase of a long-running and wide-ranging research project, *Caring for Management*, which explores managerial work and behaviour in health care. It provides the background for more detailed, in-depth, qualitative investigations into real-life complexities of managerial work (Noordegraaf and Meurs 2001a, 2001b, 2002a, 2002b). In 2000, a questionnaire was sent to about 900 Dutch executives in different health care organizations throughout the field of health care (hospitals, mental hospitals, elderly homes, etc.). These executives are members of the Dutch Association of Health Care Executives (NVZD), which covers about 95 per cent of all top executives in Dutch health care.

About 450 questionnaires were returned, so a response rate of 50 per cent was realized. Numerous questions were posed in order to trace four specific executive *profiles* that shed light on organizational (re)form and executive behaviour: *biographical* profile (age, education, schooling), *organizational* profile (type and size of organization, reform types), *mental* profile (perceptions, roles) and *behavioural* profile (issues, work and contact patterns). Questions were developed on the grounds of literature searches, document studies and open interviews. In a ‘pilot’ phase six respondents tested the questionnaire. The questions that were posed and that will be used beneath to analyse organizational reform in managerial behaviour are summarized in Table 2.

Although later investigations will put more emphasis on in-depth interviews and observations of health care managers ‘in action’, there is no need to reject the use of questionnaires. Questionnaires enable us to get a broad overview of multifaceted contemporary movements; many questions provide ‘hard’ data, e.g. on careers and size, which will not be manipulated. Moreover, questionnaires enable us to trace developments over time, and they provide starting points for empirical ‘tests’.

Questionnaire outcomes were analysed by tracing *descriptive* statistics (percentages, means, mode and medians), as well as *associations*. Beneath, we will only present significant associations ($p < 0.05$). So, if associations are insignificant, between a specific type of reform and for example organizational type or size, it will not be mentioned. To find associations Cramers V was used for nominal variables, Spearman’s Rho for ordinal variables and Pearson correlations coefficient for interval and ratio variables. In case of non-linearity we also used the Spearman’s Rho. To test the differences between categories of independent variables the *T*-test and the One-Way ANOVA were used for the interval and ratio variables, the Mann-Withney-U test and the Kruskall Wallis test for the ordinal variables and the Pearson chi- square for the nominal variables. As far as nominal variables were concerned there was no appropriate distance measure available for a direct cluster analysis. Therefore the Homals analysis was first used to construct ratio variables. To find homogeneous, non-arbitrary clusters, based on selected characteristics, we performed an extra hierarchical cluster analysis on the Homals-object scores, using the Ward method.

Table 2. Questionnaire: relevant data

Type of data	*Data*	*Operational measures*
Managerial background	• Sex	• Male/female
	• Age	• Date of birth
	• Education	• University/vocational schooling
	• Management education	• Management programmes/training
	• Career	• Management/executive positions, inside/outside health care, types of organizations
Organizational context	• Type of organization	• Hospital, nursing home, psychiatric institution, care for the handicapped, conglomerate, home care
	• Size of organization	• Budget, staff, number of professionals
	• Nature of production	• Beds/places, patients/clients
	• Organizational (re)forms	• Types of reform
Managerial perceptions	• Role patterns	• Role importance and role strength
		• Frames of reference
Daily behaviour	• Issues	• Internal/external, line/staff, planned/unplanned, strategic/operational issues
	• Contact patterns	• Internal/external contacts
		• Meetings

Source: Overview of questionnaire 'Caring for Management' (2000).

FINDINGS: ORGANIZATIONAL (RE)FORMS

We have found four major types of reform, aimed at transforming organizational forms so that management can be more rational, client-oriented and professional. These reform types are: strategic apex reform, reformed organizational structures, reformed management of professionals and reformed interorganizational relations. As argued, for each type of reform, we will present *descriptive* statistics – how many organizations are changing organizational forms? – as well as *associations* – what are the links between reform and (organizational and managerial) context? At the end of the paragraph we will also explore *associations* between the various types of reform. In the next section ('Findings: Managerial behaviour'), we will trace links between organizational (re)forms and managerial behaviour.

Strategic apex reform

The first type of reform concerns changing the strategic apex of health care organizations. Many organizations are changing from a *traditional* apex, with

traditional ‘directors’, with a clear-cut jurisdiction, to *modern* ones, with CEOs and an executive board with a broad jurisdiction and a broad set of responsibilities. In line with the *governance* movement, health care organizations function under a two-tier structure involving a supervisory board that supervises policy and actions of the executive board that is formally and factually responsible for the functioning of the organization. In both cases, two types of variations might occur: the strategic apex might consist of one or more directors; in the case of two or more directors, responsibilities might be shared or one director might be end-responsible. So, the following forms might occur:

- Single director.
- Multiple directors, shared responsibilities.
- Multiple directors, one director with end-responsibility.
- Executive board, single member.
- Executive board, multiple members, shared responsibilities.
- Executive board, multiple members, one CEO.

In most organizations the strategic apex has been altered. More than *three-quarters* of the responding organizations have introduced executive boards, mostly in the second half of the 1990s. Most executive boards have *two* or *three* members, and most boards with multiple members have *shared* responsibilities and act as a collective administration with a chairman in the role of ‘first among equals’. Most correlations between this type of reform and context appear to be insignificant, apart from the following correlations:

- Organizationally, the *type of organization* matters: in hospitals, psychiatric institutions and care for the handicapped, it is more likely that strategic apexes have been modernized; in home care it is less likely.
- Organizationally, executive boards are more likely to be introduced in *larger, profession-based* organizations with more professionals.
- Managerially, especially executives who have *managerial backgrounds*, especially inside health care, in different sorts of organizations, introduce executive boards; they do not occupy executive positions for the first time, but they are still quite new at their job.

Reformed organizational structures

The second type of organizational reform concerns changes from traditional, *functional* structures, to *process-based* structures, in which a bureaucratic logic is replaced by a client logic. In the latter case, the client or patient ‘flow’ is considered to be crucial: the organizational structure is based upon the services that are being delivered, instead

of organizational units that deliver parts of services. So, in the case of a hospital, instead of outpatient-clinical-nursing departments, the structure is organized around patients who might go from department to department. The structure is '*overturned*', as it is called in The Netherlands. New organizational units, which are product-based, might be *clustered*, or not. In other words, the primary basis for organizational subdivisions might be one type of disease or a specific client population, like children, or a combination of diseases or client groups, like children and pregnant women. So the following forms arise:

- Functional structure.
- Process-based structure, with product units, without clustering.
- Process-based structure, with product units, clustered.

Many organizations, more than *50* per cent, have been 'overturned'. This took place in the second half of the 1990s, roughly at the same time that strategic apexes were adapted (especially in hospitals and nursing homes). As far as 'overturned' organizations are concerned, two-thirds have '*clustered*' their new product units. Most product units are organized around medical *specialisms*. Again, most correlations appear to be insignificant, with the exception of the following:

- Organizationally, structures are more likely to be 'overturned' in *large* organizations, in terms of budget, staff and number of professionals.
- Organizationally, when *less professionals* are operative, the organization is slower in introducing new structures.
- Managerially, structures are slightly more likely to be 'overturned' when executives have longer *management careers*.

Reformed management of professionals

The third type of reform concerns embedding health care professionals (doctors, specialists, nurses, therapists, psychologists, etc.) within management structures. This means that professionals are made responsible, partly or wholly, for the management of health care organizations. These responsibilities can be situated at strategic or operational levels, and at both levels they can vary: they might range from voluntary co-ordination, whereby doctors are consulted, to formalized co-ordination, whereby doctors carry formal management responsibilities. In summary, the following forms might occur:

- Administrative responsibility (voluntary).
- Policy responsibility (mandatory).
- Organizational responsibility (formalized).

At the strategic level, professionals have been given *policy* responsibilities in almost 50 per cent of the cases: managers and professionals have frequent policy meetings and they make mandatory agreements. Smaller percentages carry either administrative or organizational responsibilities. At the operational level, in almost 50 per cent of the cases, professionals carry *organizational* responsibilities. In many of these cases, 'medical managers', who perform professional and managerial tasks, can be found.

Reformed interorganizational relations

The fourth type of reform concerns changes in relations between health care organizations. We will particularly focus on changing relations that result in *mergers*. Small organizations become bigger; in some cases large organizational conglomerates are being formed, which bring different sorts of organizations together, like hospitals and nursing homes and elderly care. These mergers can be of two kinds:

(1) Horizontal mergers, between comparable organizations.
(2) Vertical mergers, between different types of organizations.

Almost *two-thirds* of responding health care organizations have gone through *horizontal* mergers. Almost *half* have experienced *vertical* mergers. On average, when mergers occurred, they first occurred horizontally (around 1996); a couple of years later, vertical mergers took place (around 1999). In terms of correlations between mergers and organizational or managerial variables, the following significant correlations can be found:

- Organizationally, the *type of organization* matters: horizontal mergers are less likely to happen in psychiatric organizations and home care (where horizontal mergers have happened in home care, they have happened earliest, in 1994); vertical mergers are less likely to happen in hospitals and care for the handicapped.
- Organizationally, horizontal mergers are more likely to happen in *large* organizations, in terms of budget, staff and professionals, as well as number of beds/places; vertical mergers occur more frequently in *large* organizations, in terms of number of professionals and places.
- Managerially, horizontal mergers are more likely to happen when executives have occupied more *management functions* inside health care, when they have not been executives before and when executives have had management education.

Reform context

When we analyse and sum up the aforementioned correlations between organizational reform and organizational/managerial context, the following conclusions can be

drawn. Four variables seem to influence where and when reform happens. First, the *type of organization* is influential: the nature of care delivered influences apex reform and changes in interorganizational relations. Second, *size* matters: the larger the organization, the likelier and the earlier reforms. Third, the *professional base* of organizations counts: the more professionals, the more likely apex reform and organizational restructuring. A strong professional base, it might be concluded tentatively, contains pressures to install *counterweight* (executive board) and mechanisms to *control* (organizational structure). Fourth, *managerial careers* count. The more managerial expertise and experience – earlier management positions, management education – the more likely reform, up to a point: too much experience reduces the likelihood of reform. In order to introduce reform, it might be concluded, managers must be experienced, but not too much, they must have a 'fresh' outlook.

When these conclusions are used to test the aforementioned hypotheses, the following outcomes can be traced. There is evidence to say that 'Managers with 'managerial' backgrounds will be more likely to rationalize organizational forms' (*Hypothesis 1*). The nature of managerial backgrounds affects changes in strategic apexes, structures and interorganizational relations. They are most likely to happen when executives have been managers and executives before, especially in health care, but not too long – when they have 'fresh' outlooks – and when they have attended management training programmes. There is not much evidence found to support the conclusion 'Organizations with many clients and high client turnover are more likely to introduce client-based organizational forms' (*Hypothesis 2*). The number of client contacts mainly affects changes in strategic apexes, but these hardly count as 'client-based' forms. Professionals, budgetary size and number of staff are more important. Finally, there is some evidence to draw the conclusion 'Organizations with many professionals are more likely to professionalize organizational management' (*Hypothesis 3*). The number of professionals mainly affects interorganizational relations (mergers) and apex reform. Executives try to establish professional counterweight and control.

The previous paragraphs raise a final empirical question: to what extent can we observe interrelations between the four types of reform that have been explored? To what extent do changes in strategic apex, organizational structure, professional responsibilities and interorganizational relations go together? Can we identify ideal-typical clusters? Statistical analysis indicates that such *reform clusters* can be identified.

Three clusters appear to be dominant (see Table 3). First there is an organizational cluster in which apex reform is lagging behind. These organizations, many of which are found in the field of care for the handicapped, still have a functional structure and their professionals have minor managerial responsibilities. Organizations that belong to this cluster can be called *conservators*, as they conserve traditional structures. Second, we see a cluster of organizations, especially in home care, which have either have neither adapted their apexes, nor introduced a small board of directors. They have, however, adapted organizational structures, mainly in order to meet geographical demands. These organizations are geographically dispersed. As they mainly struggle with the

Table 3: Reform clusters

Conservators	*Distancers*	*Divisionalizers measures*
• Little apex reform • Functional structure • Little managerial responsibility for professionals	• Little apex reform • New organizational structures, geographical logic	• Executive board • New divisionalized structures • Management responsibilities for professionals

distance between 'head-quarters' and field units, we can call them *distancers*. The third cluster, to which many hospitals, merged conglomerates and psychiatric organizations can be said to belong, has a modernized strategic apex, based on a governance model. Their structures have been 'overturned' and divisionalized. Professionals carry strategic and operational responsibilities for the management of the organization. We can call them *divisionalizers*.

FINDINGS: MANAGERIAL BEHAVIOUR

The next empirical question is: to what extent and in what ways can we trace links between organizational reforms and managerial behaviour? To what extent and in what ways do responsibilities, roles and relations change?

Responsibilities

In this section, responsibilities will be perceived in terms of *issues* that are being treated. We have asked health care managers to indicate the amount of time they spend on internal and external issues, line and staff issues, planned and unplanned issues, as well as strategic and operational issues, so that the extent of their 'strategic' outlook can be captured. The outcomes are as follows:

- Executives spend *two-thirds* of their time on *internal* issues, and *one-third* on *external* issues.
- They spend over *one-third* of their time on *line* issues and almost *two-thirds* on *staff* issues.
- They spend more than *three-quarters* on *planned* issues, and almost *one-quarter* on *unplanned* issues.
- They spend more than *50* per cent on *strategic* issues, and less than *50* percent on *operational* issues.

As far as correlations between responsibilities and types of reform are concerned, not many significant correlations can be found, except the following:

- In case of 'overturned' organizations (organizational structure), executives are more likely to spend time on *planned* issues.
- In case of vertical mergers (interorganizational relations), it is more likely that executives spend *less* time on line issues and *more* on *staff* issues.
- *Size* matters: in organizations with more beds, executives are more likely to spend time on *line* issues; in organizations with more budget, staff and beds, they are more likely to spend time on *strategic* issues.

Roles

In order to trace role patterns and investigate whether executives play 'entrepreneurial' roles, we have asked respondents to indicate which roles they perform. We confronted them with a list of possible roles – figurehead, strategist, entrepreneur, liaison, manager, director – and asked them to indicate the *importance* of each role, as well as the *extent* to which they perform each role (*strength*). The outcomes are as follows:

- On average, executives want to be *strategists* and *entrepreneurs*. They also favour the figurehead role. They do *not* really like the remaining roles, especially the role of manager.
- In terms of *strength* of role performance, executives indicate they are strategists and entrepreneurs, as well as figureheads, although to a *lesser* extent than they would like to be. They also indicate they are more of a *manager* than they would like to be.

We also asked how they interpret production figures, like budgetary figures. They favour interpretations in terms of 'optimization of production processes' and 'economic health of organization' – which are, one could argue, '*managerial*' interpretations – as well as 'meeting societal requests'. This adds up to a combined *societal-managerial* frame of reference. Other interpretations, like 'meeting political requests' or 'quality' or 'strengthening competetive stance', are considered to be less important. When we look at correlations between roles and types of reform, the following patterns arise:

- Executives in adapted strategic apexes are more likely to emphasize liaison and entrepreneurial roles.
- Executives of 'overturned' organizations (organizational structure) are more likely to favour liaison and managerial roles, and less likely to favour strategist

roles; in terms of strength, they are less likely to be strategists, and more managers.

- Executives of merged organizations (organizational structure) are more likely to play 'director' and managerial roles. They are also more likely to favour political interpretations of production figures. In terms of strength, executives in organizations that have merged vertically, are less likely to be strategists and entrepreneurs.
- Executives, heading *larger* organizations with more budget, staff, professionals, beds and patients, are more likely to stress the importance of managerial roles. Executives in larger organizations with larger budget and more professionals are more likely to emphasize liaison roles. When there are less 'free' professionals, they are less likely to favour entrepreneurial roles. In terms of role strength, executives in larger organizations with more budgets, staff and patients are more likely to be 'managers' and liaisons, and they are more likely to emphasize political interpretations. When there are more patients, they are more likely to be 'directors' and are more likely to emphasize societal interpretations. When there are larger budgets and more places, they are more likely to favour economic interpretations.

In terms of day-to-day work patterns, when organizations are *larger*, with more staff, beds and places, executives spend more time elsewhere, on the road and in other organizations. In larger organizations, executives are more likely to have meetings and less desk-work (and fewer telephone calls). When organizations have more professionals and patients, time spent elsewhere is reduced.

Relations

In order to explore contact patterns and investigate whether executives become more outward looking, we have distinguished between internal and external contacts. We have asked the respondents to indicate how much time they spend on each contact. *Internal* contacts can be: professionals, nurses, peers, supervisory board, subordinate managers, employees/staff, patients/clients. *External* contacts can be: peers (comparable and different organizations), insurers, interest groups, politicians/civil servants, administrative contacts, conferences/symposia. The outcomes can be summarized as follows:

- When we cluster internal contacts, we can conclude that 60 per cent of their time is spent on *managerial* contacts (20% peers, 36% managers, 5% supervisory board). One-quarter of their internal time is spent on *employee* contacts (11% professionals, 6% nurses, 9% staff) and the remaining 6 per cent is spent on *client* contacts.

- When external contacts are clustered, it must be concluded that more than 50 per cent of their time is spent on *managerial* contacts (25% and 16% peers, 14% administrative contacts). One-quarter of their external time is spent on *field* contacts (11% insurers, 10% interest groups, 7% conferences), 10 per cent is spent on *governmental* contacts (politicians, civil servants).

When correlations between contact patterns and types of reform are explored, the following conclusions are warranted:

- A changing strategic apex goes hand-in-hand with more contacts with supervisory boards, as well as with fewer contacts with patients/clients and interest groups.
- When the organizational structure has been 'overturned', executives have more contacts with nurses.
- When organizations have merged in a vertical sense (interorganizational relations), there are fewer internal contacts with professionals and more contacts with subordinate *managers*; there are more external contacts with outside peers.
- When organizations have been 'overturned' or merged, executives have more *meetings* and less desk-work.

Behavioural context

When these findings are summarized, the following conclusions can be drawn. Two variables are important for understanding behavioural dimensions. First, *size* matters, irrespective of reforms that have been introduced (although some reforms are more likely to happen in large organizations; see the following 'Implications' section). Size influences responsibilities and roles, in multiple respects. In larger organizations, executives are more likely to focus on strategic and line issues, they are more likely to emphasize and perform manager and liaison roles and they are more likely to have 'fragmented' frames of reference (political, societal, economic). Second, *reform* matters. The more organizational reform, the more executives become 'managers' – although the managerial role is the least favoured role. Organizational reform implies that more attention is paid to planned issues and staff issues, that managerial roles become more important, and that contacts with managers/executives become more important.

Both conclusions show that health care reform contains *contradictory* tendencies and fuels *confusion*. When we focus on role importance, it is obvious that present-day executives do *not* want to be 'managers'. They want to be 'strategists' and 'entrepreneurs'. At the same time, they *must* be managers, more than they like. This becomes clear when we focus on role strength: the average respondent indicates he is

more of a manager and less of a strategist and entrepreneur than he likes. He also indicates that he favours business-like interpretations of 'facts and figures' – in addition to societal interpretations – that he emphasizes internal, planned and staff issues and that he has many management contacts. This becomes stronger when organizations are bigger and when there is more reform. Although executives want new '*exotic*', because of outside pulls, but they must be '*down-to-earth*' managers because of strong organizational pulls, especially in large organizations.

When we use these conclusions to test the hypotheses on behaviour, the following outcomes can be traced. There is evidence found to say 'Modernized organizational forms will go hand-in-hand with strategic responsibilities' (*Hypothesis 4*). Organizational reform gives rise to a 'strategist' outlook, although most time is spent on planned internal staff issues. There is some evidence to conclude that 'Modernized organizational forms will go hand-in-hand with entrepreneurial roles' (*Hypothesis 5*). They also give rise to strategic roles, both in terms of preference; in terms of real-life behaviour, executives are forced to be 'managers', more than they want to be, and liaison and 'director' roles are performed more as well. In terms of frames of reference, executives indicate they have a dual role orientation: managerial and societal. There is hardly any evidence to conclude that 'Modernized organizational forms will go hand-in-hand with external relations' (*Hypothesis 6*) and when external relations are established, they most often concern executives of other organizations.

IMPLICATIONS

The most striking observations that were presented above can be summarized as follows. First, we observed that organizational *reform* is a *widespread* phenomenon in Dutch health care. A great number of organizations (two-thirds) have adapted their strategic apexes and they have gone through mergers. Many organizations (more than 50 per cent) have adapted – 'overturned' – their organizational structures and they have adapted the role of professionals in management. Because of the rapid spread of such managerial movements, it might be plausible to conclude that some sort of 'snowball' effect or '*mimetic*' process is operative: organizations change, because other organizations change. Such mimetic dynamics are, of course, intrinsically bound up with the managerial movements themselves. 'Professional' managers must do what other professional managers do.

Second, several variables are important for understanding organizational reform. One of the most important variables is *organizational size*. It influences where reform takes place, and what behaviour occurs. This is not unimportant, as managerial movements in health care show a tendency to support 'bigness'. This, as we saw, inheres in the nature of reform. Rational organizations and client-orientations almost coerce organizations to become large.

Third, health care management is characterized by *contradictions* and *confusion*. There is an obvious tension between adapting responsibilities, roles and relations, so that more strategic and entrepreneurial management is realized on the one hand, and a 'narrow' managerial focus on internal, economic, staff issues. Present-day executives want new '*exotic*' roles, because there is an outside pull, but they must also be '*down-to-earth*' managers because there is an organizational pull, especially in *large* organizations. In this respect, 'big is not beautiful' (cf. Herzlinger 1997).

This has several implications. First of all, managerial movements as such, although pretending to introduce clear and consistent health care management, do *not* provide clarity and consistency. On the contrary, managerial movements complicate managerial reform. The organizational pull to be down-to-earth managers is, paradoxically, strengthened by attempts to make health care organizations more business-like. The organizational pull is pushed ahead. Second, when we stick to mainstream managerial movements, it means that these movements must meet certain demands. Professional managers, for instance, must be able to manage contradictions and confusion, instead of merely introducing seductive business-like models. Rational and client-oriented management must acknowledge the inevitability of organizational barriers, instead of sticking to business-like imagery. Third, managerial movements as such will have to be criticized. Instead of mainstream movements, focused on rational, client-oriented and professional management, other movements might be more important. Management models should not primarily come from business administration and economics, but from political science, public management and organizational sociology, which focus on professionalism, politics, ambiguity, accountability and the like. Thus, realities of health care management are acknowledged and more adequate management insights can be developed. In that way, it is possible to understand how managers can push and pull, when they are pushed and pulled.

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REFERENCES

Aucoin, P. (1990) Administrative Reform in Public Management, *Governance*. 2 pp115 – 35.

Busse, R., Wismar, M. and Berman, P. C. (2002) *The European Union and Health Services*, Amsterdam: IOS Press.

Clarke, J. and Newman, J. (1997) *The Managerial State*, London: Sage.

EOHCS (2002) *Health Care Systems in Eight Countries*, London: LSE.

Ferlie, E., Ashburner, L., Fitzgerald, L. and Pettigrew, A. (1996) *The New Public Management in Action*, Oxford: Oxford University Press.

Flood, C. M. (2000) *International Health Care Reform*, London & New York: Routledge.

Hammer, M. and Champy, J. (1993) *Reengineering the Corporation*, New York: Harper Business.

Herzlinger, R. E. (1997) *Market-driven Health Care*, Cambridge: Pearson Books.

Hood, C. (1991) A Public Management for All Seasons?, *Public Administration*. 61:1 pp3 – 19.

Kickert, W. J. M. ed. (1997) *Public Management and Administrative Reform in Western Europe*, Cheltenham: Edward Elgar.

LeGrand, J. (2001) *The Quasi-market Experiments in Public Service Delivery: Did They Work?*, London: University of Siena.

Mintzberg, H. (1983) *Structure in Fives*, Englewood Cliffs.

——(1997) Toward Healthier Hospitals, *Health Care Management Review*. 22:4 pp1 – 9.

Newman, J. and Clarke, J. (1994) 'Going About Our Business?' in J. Clarke, A. Cochrane and E. McLaughlin (eds) *Managing social policy*. London: Sage.

Noordegraaf, M. (2000) *Attention! Work and Behavior of Public Managers amidst Ambiguity*, Delft: Eburon.

——(2004) *Management in het publieke domein* (Management in the Public Domain), Bussum: Coutinho.

Noordegraaf, M. and Meurs, P. (2001a) De zichtbare manager (Visible Managers), *ZM Magazine*. 17:1 pp2 – 6.

——(2001b) Managers aan de macht (Managers in Power), *Holland Management Review*. 56:79 pp74 – 84.

——(2002a) '*Harde' feiten uit een 'zachte' sector* ('Hard' Facts from a 'Soft' Sector), Rotterdam: Instituut Beleid en Management in de Gezondheidszorg.

——(2002b) Verwarde managers (Confused Managers), *M&O*. 56:3 pp22 – 39.

Pollitt, C. (1993) *Managerialism and the Public Services*, Oxford: Blackwell.

Pollitt, C. and Harrison, S. (1994) *Controllling Health Professionals*, Buckingham.