

Comment

Reflecting on ‘The complexity of governance change: reforming the governance of medical performance in Germany’

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“The governance of medical performance consists of all those mechanisms that together influence the performance of medical work in terms of either diagnosis or treatment, broadly understood”. This definition is at the core of Burau’s paper from 2007. The paper uses recent contributions to the public administration/governance literature to “explore the co-existence of different forms of governance with the aim of assessing the relative extent and the substantive nature of governance change” (Burau, 2007). The main contribution is thus to apply governance theory concepts within health care (in Germany) and to illustrate this by analyzing development trends in the governance of medical performance using Germany as an example. The analysis of governance changes in Germany convincingly shows the merits of this type of meso-level analysis for understanding the complexities of governance changes and draws out a number of interesting conclusions.

In theoretical terms the paper distinguishes between four ideal-typical forms of governance of medical performance. *Professional self-governance* is based on expert authority and professional control over clinical practice through peer review and professionally defined clinical guidelines and codes of practices. This type of governance was at the core of the historical compromise between the medical profession and the state, whereby professions gained a privileged status in return for their contribution in rationing health services. However, most industrialized countries have a strong public involvement in health care and therefore also rely on *hierarchy*, which is the second ideal-typical governance form for medical performance in the paper. Hierarchy is based on formal authority within parliamentary chains of command with politicians at the apex and bureaucracy to support decision making and implementation. Standards for medical performance

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are set centrally, and not exclusively by the medical professions. Indeed, the governance of professions become part of the bureaucracy as professionals are employed and subjected to accountability relations within state bureaucracy (NHS) or decentralized authorities (Nordic countries). The third governance form for medical performance is *market*. This is presented in broad terms as the use of managerial power and the introduction of various types of competition and performance-related payment. Benchmarking and ranking are important as information sources to facilitate the ‘markets’, and there is a strong emphasis on cost-efficiency and effectiveness in the governance of medical performance. The fourth and final ideal-typical governance type is *network*. This is based on inter-dependent flows of power, for example, negotiations among providers, purchasers and professional organizations about standards.

Changes in governance can take place *within* the professional, hierarchy, market and network governance forms, or *between* the forms. Changes between forms can lead to hybrid governance modes or increasing importance of one or more form at the expense of others (Jørgensen and Vrangbæk, 2004). The result may be tensions within or between different modes of governance.

Using these four ideal types the paper shows that medical governance in Germany has changed in several important ways from the traditional starting point (pre-1990s) to 2007. The general trend appears to be an expansion of the network and hierarchy governance. This is seen in the expansion of the scope of the joint self-administration (a German network/hierarchy hybrid) into the field of quality assurance and centralized standard setting. An Institute for Quality and Efficiency is established to support this and the Joint Committee is extended to include a sub-committee on co-ordination, charged with, among others, defining treatment guidelines for inter-sectoral care. New forms of contracting are introduced and clinical guidelines become part of the contracting demands. In addition, we see the ‘shadow of the hierarchy’ becoming stronger, in the sense that the federal government takes a stronger role in setting deadlines for agreements and implementation by the joint self-administration partners.

The analysis on the one hand manages to draw out development trends in medical care that seem very familiar across different health systems, and on the other manages to show how these general trends play out in quite specific ways in the specific institutional setting of the German health care system. The paper thereby clearly establishes itself as an important contribution to our understanding of health system governance. However, as with all good works it also leads to reflections and thoughts on how the perspective might be developed further and applied in follow-up analyses across different country units.

A first point to notice is the rather undeveloped nature of the market perspective. It is stated that market governance implies an emphasis on competition and performance-related payment. Benchmarking and ranking become important as information sources to facilitate the ‘markets’, and there is a strong emphasis on cost-efficiency and effectiveness in the governance of medical performance.

Yet, the lines to both hierarchical and network governance remain somewhat blurred. It is hardly an exclusive trait of market governance to emphasize effectiveness and cost-efficiency. Indeed, it has for many years been a key task for hierarchical governance to be guardians of both proper and efficient use of public resources. To this end, there has been a development of budgeting and accounting systems as well as various systems for tracking activity. In other words, distinctions between the two are less clear cut than suggested, or the lines between the two have been flexible for some time. It could also be argued that benchmarking and reputational competition has been a feature of professional governance for many years. Many hospital professionals compare performance with other similar departments, and the collection of data into clinical data bases has facilitated this. The main point is therefore not about competition *per se*, but about the control of data used for benchmarking and the potential for tying such performance data to implicit or explicit incentives. In any case, it is clear that much more work can be done in clarifying the features and consequences of this particular mode of governance and its interaction with other forms.

It is noteworthy that the market perspective is not given any weight in the empirical analysis of the German case. This could be taken as an indication that market rhetoric had not played a significant role in German health policy until 2007. However, it is more reasonable to view this as an illustration of the hybrid nature of German health policy, and of the ambiguity about this analytical concept, as several elements that might be discussed as market governance components are in fact seen as developments within the hierarchical or hybrid network-hierarchical governance mode.

A second topic to consider based on the governance approach is the question of consequences of developments in governance. Although governance studies have been very sophisticated in analyzing developments, there has been much less attention paid to rigorous analysis of the ensuing consequences. Interesting observations about tensions within and between governance forms are presented by Burau. However, it is not further explained how those tensions become manifest, and what the consequences of such tensions might be. It is implicit in the analysis that tensions are problematic; however, that need not be the case. They could perhaps also be drivers for further development. In any case, it would be useful to analyze the consequences of governance changes and tensions, seen from both a systemic (top-down) perspective and from the viewpoint of the actors and organizations subjected to the various governance regimes. There are some indications in the paper that the density of governance pressure increases over time. Can this be confirmed in other countries, and if so what are the relative costs of the higher density of governance compared with the system-level benefits?

A third topic that would be very relevant for follow-up studies is the observation that classical professional self-governance remains important in spite of the expansion in the scope of hybrid joint self-administration and hierarchical governance. It is highlighted that both of these governance types play a stronger

role in setting standards, developing clinical guidelines and monitoring medical performance. Yet, professional self-governance remains at the core of medical governance, and serves as an implementation filter for the other governance types. This is an important issue to analyze in an international perspective. How are the boundaries drawn between professions and hierarchy/network and to what extent have medical professions maintained control over performance measurement and the production of standards and guidelines for medical practice? How may comparative differences be explained by differences in the institutional structures and development paths in different countries?

This leads on to the fourth issue for broader discussion and follow-up studies. The analysis of Germany indicates that the (federal) state became a more dominant governance player over time (along with and to some extent in a conflicting relationship to the joint self-administration). In a sense, the state assumes a meta-governance role of setting the boundaries and developing the mix of governance forms and mechanisms applied at the clinical level and in the joint self-administration. The state assumes the role of “architect of the political order” (Döhler, 1995). This leads to two important questions for further study. First, whether a similar assertion of the central state is seen in other European countries – the Nordic cases of Denmark and Norway certainly point in that direction with the 2002 (Norway) and 2007 (Denmark) structural/administrative reforms. Second, how do the states fulfill this role of meta-governance? What are the policy instruments for exercising this meta-governance role and do the European states have sufficient administrative and informational capacity to take on this role in a successful manner? Third, what are the consequences of this stronger role of the central state in meta-governance, if it can indeed also be found in other health systems? One could imagine a stronger emphasis on equal standards and perhaps better co-ordination of the introduction of technology. At the same time decisions are moving further away from detailed local/regional levels and are shifting into different types of policy arenas with more general concerns and a different set of actors.

A fifth and final research topic that is highly relevant as a follow-up to the excellent paper by Burau is the issue of what drives the developments in governance forms. Stated in classical political science terms, one might point to ideas (ideology), interests or institutional processes. Ideology has certainly been a driver in introducing NPM (New Public Management) governance measures initially, but they have since been widely adopted by a broad spectrum of political actors. This might point to interest-based explanations based on assessment of differences in utility functions for political and administrative actors at different levels. Presumably, central-level administrators and politicians share an interest in implementing parts of the NPM toolkit in response to shifting contexts for health policy.

Institutional explanations would offer two important perspectives. First, that there will be a tendency to stick within specific development paths once they are

established. It would thus be important to identify the formative moments of governance paths and to trace the gradual developments within these paths. Second, institutional perspectives would point to the isomorphic spread of governance concepts across countries and systems at particular points in time. Regardless of whether one relies on ideas, interest or institutional explanations, it would be relevant to consider some of the contextual changes influencing governance developments. Three contextual developments seem particularly relevant. The first is the development in information and communication technology as an important driver and facilitator of the governance changes. The second is the overall macro-economic development, and the third relates to aging populations and changing disease patterns.

All in all the paper by Burau is strongly recommended, and it remains a valuable contribution to *HEPL*. It opens up a number of research questions and debates for detailed and comparative investigation in the future.

References

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