Reclaim the profession!

Norway has the preconditions for world-class health services. They should enjoy the confidence of all social strata, be organised by the state and provide maximum benefit in exchange for the resources that the community invests in them. Everybody agrees to these general goals. The disagreement pertains to the means. The Minister of Health prescribes a steady course; we believe that a steady course will lead us increasingly further from the goals. We can see clear signs of deterioration in the health services. A radical change of course is required.

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Here we will first analyse the current management ideology and it consequences. Then we will present an alternative management ideology and its consequences, and describe how it should be implemented in practice.

What characterises the current management ideology?

Since the 1990s, Norwegian public administration, including the health services, has been reformed in the direction of «New Public Management» (NPM) (1, 2). This management ideology is manifested in the health enterprise reform, the interaction reform, hospital reorganisations with large mergers and «crosswise departments» etc. (3). Three characteristics are particularly important:

Simultaneous expansion of market power and government power. New Public Management involves introduction of both market mechanisms and control routines. The ideology borrows freely from the right as well as the left wing of politics. Public administration becomes a strange combination of business and bureaucracy, where the business is characterised by a liberalist mindset and the bureaucracy by an expanding system of monitoring and reporting that signals a fundamental distrust in the health workers.

Demands for loyalty «upwards». The rank and file – we who cater to the fundamental tasks of the health services and bear personal responsibility in the encounter with the individual patients – are faced with a demand for loyalty to our leaders, who in turn are loyal to the levels above. Thus, autonomous professionals are turned into disciplined officials. In New Public Management, independent norms, for example traditional medical ethics and assessments of medical appropriateness, are displaced by what «the line» decides.

Delegation of responsibility and dilemmas «downwards». While loyalty upwards is demanded, responsibility and dilemmas are shifted downwards, initially from the political to the bureaucratic level. The health enterprise reform is a prime example. Now, the general responsibility for the activities of the hospitals no longer rests with the politicians, but with the enterprise boards, as the Minister of Health has repeatedly pointed out (4). In the next round, the dilemmas are delegated all the way down to the rank and file, who must fulfil the obligations of the welfare state without being supplied with sufficient resources. «For example, government ministers may at one point in time guarantee a certain level to all users of care and nursing services, allocate too scarce resources at the next, and subsequently re-emerge as advocates of those who fail to have their rights fulfilled at a third» (5, p. 13).

What are the consequences of the current management ideology for the health sector? New Public Management was introduced for reasons including the need to control public expenditure and public employees. We have no reason to doubt that the intentions were impeccable. Now, however, the baby is being thrown out with the bathwater. Here are some examples:

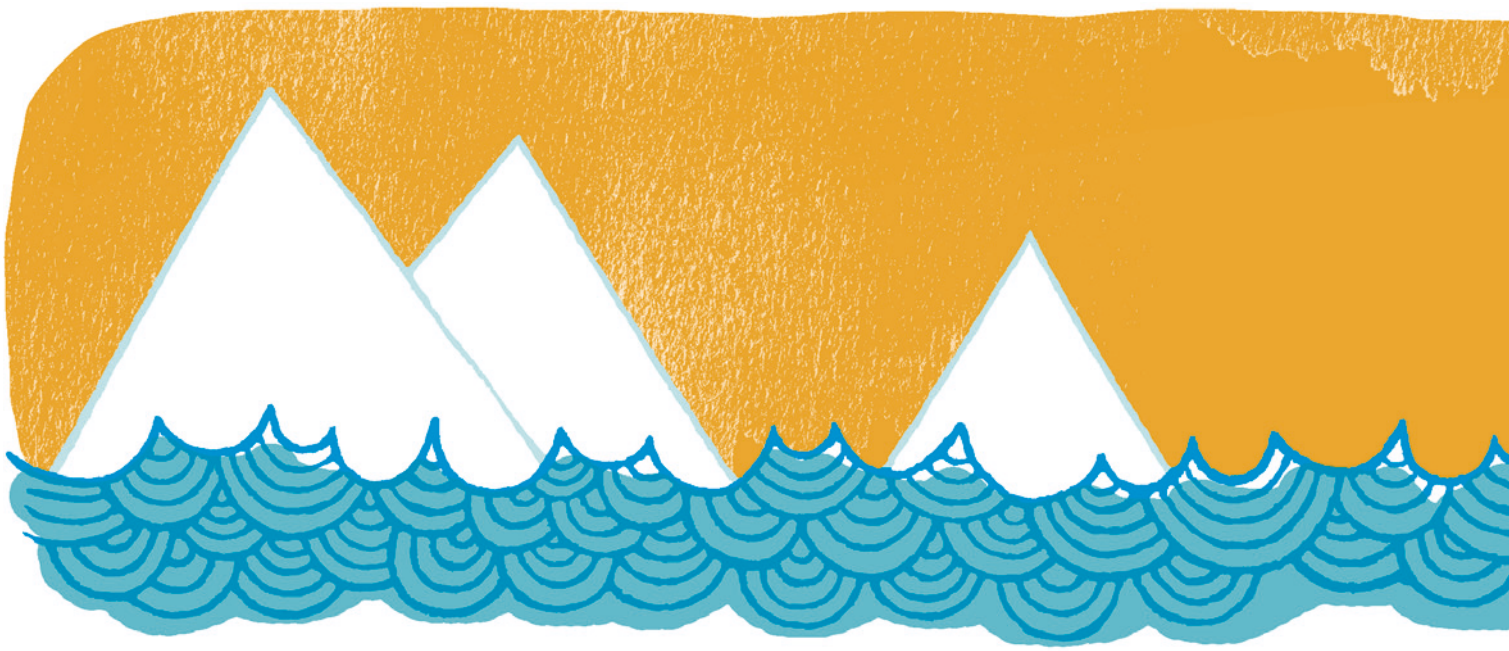
Poorer clinical services. The capital-city process has not improved the clinical services (6). This is in line with experience internationally (7). Care services for the elderly are already in poor shape in many places, and the interaction reform comprises elements that will exacerbate this situation (8, 9). Experienced doctors must spend so much time on meetings and reporting that the follow-up of patients is significantly weakened. The patients' confidence in the system erodes. This confidence is not only a key precondition for good services, but also a goal in itself (10).

Financial inefficiency. The alleged potential for cost savings inherent in New Public Management has not been documented. On the contrary: hospital mergers often lead to higher real costs (7, 11, 12). Increasing bureaucratic control in itself represents a cost – today there are more administrators than doctors in Norwegian hospitals. At the same time, control regimes may cause the «rank and file» to be less efficient (13).

Democratic deficit. When responsibility moves from politicians to bureaucrats, power moves with it. Government by the people thereby erodes, as shown by the study of power and democracy (2). Bureaucrats never face elections. When the most important decisions are made in the boardrooms, political discourse erodes into empty rhetoric.

Competence drain. When combined with demands for loyalty, the delegation of dilemmas gives rise to moral conflicts in the individual health worker (14–16). One is faced with an impossible choice – loyalty to «the line» versus loyalty to the individual patient. Working ever faster may provide a short-term solution. The long-term effect consists in de-motivated health workers, a declining sense of personal responsibility and exit from the profession (17, 18).

Moral decay. Another possible approach to these conflicting moral pressures is to renounce one's ideals. A de-humanisation of the health sector may occur if the traditional values of the health professions are displaced by technical-financial vocabularies, ideas and actions. It is symptomatic that the



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Minister of Health as well as the Prime Minister distance themselves from tragic individual cases that have been brought about by reorganisation and system failure by pointing out that the quality of the health services is high «on average» (4, 19). It will be a sign of moral decay if health workers start thinking in the same terms.

The system of performance-based funding (PBF), another legitimate offspring of New Public Management, provides an apt illustration of many of these negative consequences (20): Clinical services deteriorate in quality, since priority is given to «profitable», rather than «unprofitable» patients. Financial efficiency is weakened – partly because the coding itself steals resources from the primary activities, partly because the incentives embedded in the system shift the activity towards what generates income for the department instead of what would be a sensible use of resources for the community. Moral language is displaced by financial cost-benefit analyses, and being a skilful DRG coder will in some places provide more prestige and career opportunities than being an empathic care worker.

Against this background, it is remarkable to see that the Minister of Health insists on the superiority of the current management ideology (4, 21). This can only be explained by the fact that the ideology has become its own justification – it is not based on empirical verification, nor on rational justifications (3), and moreover it has fully demonstrated its unfortunate effects in other sectors of society as well (22). It can lead the health services in a direction which is diametrically opposed to what the minister professes to desire, and entail a deconstruction of public welfare.

The general practitioners have witnessed how the specialist health services are being surrounded by constantly new layers of administration that complicate their contact with hospital colleagues. The regulatory zeal of the central health authorities reached the general practitioners in 2011, in the form of new draft regulations for the regular GP scheme. They were supposed to ensure the quality of the primary services by regulating the doctors' activities in detail, under threat of sanctions. The proposal was perceived as expressing distrust in the regular GPs (RGPs). The response came in the form of rapid mobilisation, in which more than two-thirds of the nation's RGPs united in a letter to the Minister of Health. The letter made it clear that the priorities and choices made by the RGPs should be based on medical considerations, not on the administration's need for control and regulation (23). While the general practitioners have so far in part succeeded in maintaining their required professional integrity, their colleagues in the hospitals have lost professional terrain during the last decade (24).

A new management ideology for the health services

A new management ideology for the health services is called for. The health professions need to rediscover their historical value base, founded on the unique encounter between the helper and the one who needs help, between the health worker and the patient (25). This encounter – the clinical consultation – constitutes the universal obligation of the health professions: to work for the health of *the other*. «The doctor's master must be the patient» (26).

This value base places care for *the individual* at the centre. The remit of the health workers is not to serve society or their own interests, but to help the suffering individuals who come their way. Furthermore, this value base is intimately *embedded in the professions*: Those who practise the profession, in cooperation with the patient, must determine what will benefit the other's health (25). This value base is not associated with any political leanings and cannot be categorised as rightist or leftist. As such, it may function as a unifying factor for all health workers, irrespective of political viewpoints and independently of their role in the health services. It remains important from the initial contact through the primary health services throughout the course of diagnostics and treatment.

The value base can be drawn from two philosophical schools. First, from the *ethics of proximity*, developed by the philosopher Emmanuel Lévinas (1906–1995), which are based on the unique relationship between the «I» and the «Other» (27, 28). In ethics of proximity, moral actions are not a product of rational and abstract considerations, but rest on my responsibility for «the other». This alone will not make one «short-sighted» (28). The transfer value to the health professions is obvious (29). Second, from *Aristotelian ethics*, which are similarly based on the specific purpose of a given practice – in our case, the patient's health (30, 31). Health workers must develop the virtues (character traits) that the practice in question requires. This includes development of our intellectual and rational capabilities, but these cannot be decoupled from practices. Aristotelian ethics are therefore also critical of a context-independent rationality as a basis for moral actions.

Both of these philosophical schools may motivate a sharp criticism of the manage-

ment ideology that prevails in the health services. Loughlin, who belongs to the Aristotelian tradition, points to the cynicism inherent in contemporary discussions of priorities: One is concerned not with the suffering of people, but with whether this suffering may be unfairly distributed (31). On the basis of ethics of proximity, Nortvedt similarly warns against reducing «the other» to an anonymous number in the crowd (29).

What will be the consequences of a new management ideology?

The traditional value base of the health professions must be reinstated as the basis for the organisation of the health services. Such an ideological shift is radical and future-oriented. The patients' confidence in the health services has been re-established when they can be certain that the therapist has only one agenda – their health and well-being. Health workers will have a better work situation, and will therefore perform better when the conflicting pressures between the two requests for loyalty recede. In itself, this will account for major social gains.

The Minister of Health argues that the authorities must monitor the activities of the health services for reasons of democracy (4). Another government minister from another party could have put forward the same argument, but favoured financial incentives over bureaucratic regulations. Both base their views on specific assumptions about the relationship between politics and professions. We disagree fundamentally. A democracy is characterised by the exercise of power by representative institutions, but also by contributions to the common good by individuals and civil society. A democratic society is created not only from «above», but also from «below» through the specific practices of various professions (30). Drawing this line of demarcation between politics and professions has a number of positive effects:

Clarification of political responsibility. Instead of invading the practical field of the professions, the politicians should reassume the fundamental task of politics, which is to define clear frameworks. This will be easier if the health workers resist the delegation of political dilemmas and become better at revealing the consequences of political decisions. This is a simplified example: The politicians decide how much of society's shared funds should be devoted to the treatment of malignant melanoma. The doctors report how many will survive and how many will die as a result of various courses of action. The voters decide whether or not to re-elect the politicians.

Facilitation, not micromanagement. The role of the state is to *facilitate* the socially constructive practices of the professions, and not manage the content of these practices in detail. This content must be defined by the professions themselves.

Public information and openness. An informed population is a precondition for modern democracy. Present and future patients have the right to be informed about the way the health services operate. The profession is similarly obligated to be open about these issues, and this presupposes full professional freedom of speech. A double requirement for loyalty restricts this freedom of speech and leads to the culture of fear that has been described in several hospitals in recent years. A new management ideology will promote this freedom of speech.

Better utilisation of resources. More clear-cut professional norms will render superfluous the numerous layers of administrative controls and bureaucratic structures. Cooperation between the primary and specialist health services is simplified when everybody shares the goal of working for the benefit of the individual patient, rather than winning the competition or eliminating quasi-problems created by reporting requirements and secondary goals.

Alternative public rationalities. Modern social theoreticians, such as Jürgen Habermas, emphasise that the public discourse must be nourished by different perspectives on the world. Currently, the technical-financial world view predominates in most areas of society. A clear definition of our traditional value base will demonstrate that the most important things in life cannot be measured or counted. Giving and receiving *care* is a pivotal dimension in the life of each individual as well as in human civilisation (32). As doctors we have a particular responsibility for championing professionally responsible and caring assistance to our patients.

What must be done in practice?

A new management ideology will not bring about itself. It must be established through concrete action. Some elements are of key importance:

Solidarity within and between the health professions. Our traditional value base implies unselfish service to individuals. Striving for this value base requires one to resist certain types of actions, in oneself as well as in one's colleagues. This concerns two main types in particular: *Selfish acts*, the motives for which could include one's own career, professional satisfaction, income or similar, and *acts based on loyalty*

to the system, in which the primary loyalty to the patient is sacrificed in favour of the prevailing management ideology. There are numerous examples of the former, which may help explain why the politicians want to establish stricter controls. Nowadays, however, loyalty to the prevailing management ideology is a far greater problem, which may for example explain why it has been possible to reorganise hospitals in a way that could have been predicted to cause death and suffering to individuals.

Attitude to adverse events. When something goes wrong, our attitude must be characterised by openness, credibility and helpfulness to those involved – patients as well as health personnel.

Calling attention to the resource situation. The allegedly enormous health expenditure in Norway is a persistent myth. In reality, the resource use is quite average for European countries (33). Deciding on the allocations is the privilege of the politicians, while we health workers must call attention to the consequences in a sober manner. This presupposes, among other things, cooperation with the press, rather than fear of journalists and rejection of publicity.

Specific proposals for change

Our proposals will lead to radical changes in the management structure of the health services. The ten measures outlined below are a natural starting-point for the construction of the health services of the future. These changes are necessary, but not sufficient, to achieve the general goals that have been described above.

1. Abolish the hospital boards in their present form. «Professional boards», mainly consisting of people with no background from the health professions, are not appropriate as decision-making organs in enterprises as complicated as hospitals. The existing boards are excessively serving only as an alibi for decisions made by the administration. In their present form, the boards do not contribute positively to the running of hospitals. In hospitals, the decisions must be made in the organisation and be well embedded in the professional communities.

2. Abolish «crosswise» departments that are not embedded in the professional communities. Hospital departments spread out over various geographical locations have largely helped remove or alienate the heads of department and stripped them of their natural authority. This can be rapidly reversed. All hospitals must have a locally present management.

3. Abolish the regional health trusts (the RHTs). These represent an unnecessary layer between those who are politically responsible (The Ministry of Health and Care Services) and the executive link of the chain (the hospitals). A hospital department in the Ministry of Health will be no guarantee of improvement, but maintenance of the regional health trusts will act as a barrier to fundamental improvements. The hospital department must possess competence about all regions, and maintain a close dialogue with the hospital directors.

4. Stop using performance-based funding (PBF) for internal distribution within hospitals. The PBF system for funding of hospitals has very unfortunate consequences, and should in the long term be replaced by a system that provides fewer incentives for short-term strategic considerations that are harmful for the community and individuals. In the short term, considerable gains can be made by prohibiting the use of performance-based funding for distribution of budget funds internally in hospitals. The PBF system was never intended to be used for this purpose (34), but altering the currently entrenched practices will require intervention by central-level politicians.

5. Prohibit invoicing within the public health services. Today we are witnessing invoicing between departments within the same hospital, between public hospitals and between the hospitals and the municipalities. This does not promote cooperation for the benefit of patients, it entails bureaucratisation and strategic positioning to «take the patient out of my budget and into yours». These schemes can be rapidly abolished, but as above, the initiative will not emerge from the hospitals themselves. Central-level measures are required.

6. Slenderise the Ministry of Health and Care Services and the Directorate of Health. This will have an effect at two levels. First, it will in itself free up resources. Second, bureaucracy at one level tends to reinforce bureaucracy at another: The central health administration produces regulations, reporting requirements and cumbersome administrative schemes, and to comply with them, the hospitals and municipalities need to expand *their* bureaucracies. Halting this growth will require resolute action, which quite naturally will be opposed by the bureaucracy itself. As a start, one could introduce a recruitment ban in the ministry and the directorate. Such measures are used on a regular basis with regard to therapeutic professions in the health services. It is a paradox that this evidently appears to be quite unthinkable with regard to groups of personnel with no therapeutic responsibility.

7. Slenderise the hospital bureaucracies. Health personnel see that a lot of time that should be spent on treating patients is diverted in favour of meetings, reporting, secretarial work etc. «Efficiency enhancement measures», such as introduction of speech recognition and reduction in the number of auxiliary staff, has unfortunately defeated its own purpose. We demand a net reduction in the number of administrative staff in the hospitals, but functions that directly support the patient-oriented efforts (such as ward secretaries) must be shielded.

8. Separate investments from running of hospitals. Having to fund necessary maintenance of hospital buildings by reducing the treatment of patients is meaningless. Maintenance and new construction must be funded over the state budget, with grants that do not compete with the daily running. The building mass must comply with appropriate national standards in all regions of the country, and cannot be made subject to a continuous game to see who will be left holding the baby, and in which the provision of treatment to patients becomes a residual item.

9. No further centrally engineered desktop reforms in the health services. Reforms of the health services must be embedded in real needs at the grassroots, and not in some rather fanciful ideas from government ministers or others in power.

10. It is only by demonstrating trust in the grassroots that the leaders of the health services can earn our trust. The current system is riddled with mistrust. The repeated demands for monitoring and control are expressions of distrust in the health personnel. In turn, this engenders distrust in the management, who lose legitimacy among those they should lead. In the final account, the patients' trust in the health services – a precondition for our work – erodes. The leaders of the health services bear the responsibility for re-establishing these relationships of trust, on which our work must be founded.

A call to action

Each and every one of us – in various parts of the country and in different branches of the health services – has experienced the negative consequences of the current management culture. The primary health services and the hospitals face the same problems, although in varying forms and degrees. This development must be reversed, and it will not happen without a struggle. We know that our opinions are widely shared. However, the resistance to the current management is fragmented and uncoordinated, and thus weak. Health workers who share the fundamental viewpoints we have described are encouraged to join the e-mail list «Defend our hospitals» (*http://mailman.uib.no/listinfo/vvs*). The list is used for sharing information, discussion and planning of the necessary measures to re-establish health services that are in tune with the ideals to which we subscribe. The lowermost author of this article is the moderator/editor of the list. The time is overripe to gather our forces for a shared effort for our profession.

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