

THERE IS A NEED TO FURTHER STRENGTHEN CLINICAL SYSTEM GOVERNANCE

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ABSTRACT

The introduction of general management in healthcare has enabled the development of elaborate general management and corporate governance structures. This is supported by significant resourcing and complex committee structures.

Whereas healthcare has seen the development of a whole new general management industry to 'manage' healthcare, clinical system governance over matters to do with clinical care delivery, quality and safety have not attracted the same amount of attention and resourcing. There is an opportunity to use available expertise within healthcare systems to clinically govern clinical care delivery, quality and patient safety.

KEYWORDS

Governance, clinical governance, healthcare management.

INTRODUCTION

At least in the English-speaking world, the watershed point in terms of how health services are led and managed was the introduction of general management in health services following the Griffith Review in the United Kingdom in 1983 [1]. A thought bubble to bring in a generic manager to manage the performance of health service was embraced at that time by the then government to manage peculiar issues that had plagued the United Kingdom's National Health Service [2]. Ironically, this recommendation was made without any supporting analysis and inquiry was only into "the effective use and management of manpower and resources [1]." However, this management concept was quickly embraced by similar health systems, including New Zealand and Australia. The management of technically sophisticated and complex healthcare systems

moved into the hands of non-technical administrators and managers.

Whether clinical governance needs of healthcare organisations can be undertaken by a generic management structure is the question at the heart of this issue. Not everyone agrees it can. Moreover, this realisation started very soon after the introduction of these reforms [3, 4].

WHY THE INTEREST IN GENERAL MANAGEMENT OF CLINICAL CARE?

The significant finding made by Griffith's review was that no identified individual could be identified who was 'in-charge,' or in other words, was accountable for the management of the health services in the United

Kingdom's National Health Service then. This finding led to the recommendation that general managers be appointed. Indeed, since Griffith's review, non-clinical chief executive officers, including non-clinical chief officers at health service and health policy levels have become quite acceptable. Layers of new structural entities have been created, bureaucratic general management support structures have been developed and an army of managers appointed. To have those single points of accountability, boards of governance have been established.

Whereas the introduction of general management was widespread and seen to be an attractive remedy to address the perception of doctors in pre-Griffith's National Health Service in the United Kingdom as "professional monopolists and the dominant power group systems" [5], it also allowed the dismantling of "consensus management" that may have been seen as a reason for the absence of a single person-in-charge.

In New Zealand, 'Service Management' structures described as innovative, were introduced in the late 1980s (Malcolm, 1990). This occurred as part of wider reform of the management of government services implemented through the State Services Act of 1988. The 1993 health reforms further necessitated the health provider organisations to run on 'business lines' and with a profit motive, and therefore, formalised the position of business managers at the helm of each service [6]. In Australia, similar managerial reforms occurred although were framed differently owing to its structure of government and separation between federal (national) and state and territory government responsibilities, and how primary care is funded and managed through private providers. Nevertheless, the introduction of managerialism in the 1990s through programme structures, programme budgeting and performance measurement necessitated the transition to generic managers to manage health services [7].

WHY CLINICAL SYSTEM GOVERNANCE NEEDS SIMILAR RIGOUR AS GENERAL MANAGEMENT AND CORPORATE GOVERNANCE?

Griffith's review also made another important observation that clinicians needed to be more closely involved in making decisions about priorities in the use of resources [1]. It must be noted that with significant management failures

of the health system [8-11] there was a flurry of excitement about the necessity for good clinical system governance and the need for clinician decision-makers to govern the system, however, it seems this dissipated as quickly as the media moved on to yet another story. Whereas general management and corporate governance have continued to evolve and strengthen, an advisory hands-off role for clinicians to 'advise' on clinical system governance matters has somehow been seen to be quite sufficient. It is a pity that despite the realisation that clinicians must have clinical system governance responsibility, their role has remained limited to advising the generic management, but without specific accountabilities for clinical care delivery, quality or patient safety. Literature on health governance continues to play with the idea that health system failures were perhaps a failure of boards and senior management to fulfill their responsibility to respond to issues [12, 13].

It is interesting that even though spectacular health system failures pointed to the need for clinicians to lead and govern, the system architects of the healthcare system have continued to refer to the role of clinical governance to continuously improving quality foreshadowed in much-quoted early definition of clinical governance - "a system through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish [14]." Whereas the absence of one person "in-charge", very appropriately became an opportunity to remedy a systemic deficit in the management of health service, accountability for clinical governance remains diffuse and disorganised. Despite stark warnings that "if clinical governance is to be successful it must be underpinned by the same strengths as corporate governance: it must be rigorous in its application, organisation wide in its emphasis, accountable in its delivery, developmental in its thrust, and positive in its connotations" [14], healthcare systems have struggled to appreciate the gravity of such warnings.

Following yet more health system failures there have been cautious attempts to expand the definition to conceptualise a system that can provide "assurance and review of clinical responsibility and accountability that improves quality and safety" [15], however, a structure to ensure such responsibility and accountability be given to clinicians have remained unclear. Instead, it is even proposed that perhaps educational interventions to increase awareness of healthcare staff about patient safety and managerial intervention to improve the culture

of safety may be enough [16]. Rather than encouraging clinicians to provide much-needed clinical system governance and oversight to the clinical care system, clinicians remain sidelined with little accountability for improvement, innovation and patient safety. Whether this is because of bureaucratic interest in curbing the power of clinicians is a possibility [2, 17]. In any case, it does appear to be the reason why clinical system governance continues to be conceptualised within a general management system, almost with a desire to limit clinician involvement rather than ensuring they have this accountability.

CONCLUSIONS

Over the last three to four decades health management and corporate governance systems have evolved and matured, however, the development of necessary clinical system governance has remained unstructured and inadequate. This is likely a result of the conceptualisation of clinical system governance within the general management systems. Without structured clinical system governance, clinicians have also remained peripheral and often disenchanted and disengaged.

Clear accountabilities within an internal clinical system governance system have enormous potential for a clinical system to be effective, engage clinicians optimally and use their clinical skills and expertise. Not using this talent is a significant wasted opportunity.

A clinical system governance system must be conceptualised with similar rigour and resourcing as is allocated to service the general management and corporate governance systems in healthcare. For clinical governors to be effective, there must be a proactive investment in internal clinical networks. Accountabilities must be clear at all levels of the clinical system and clinical system governors must be intricately linked with the internal clinical system.

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