5. STRATEGIES FOR HEALTH CARE REFORM IMPLEMENTATION IN SOUTHERN ITALY

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INTRODUCTION

This study focuses on a particular type of public organization characterized by weak boundaries and strong informal relationships, elements that have assisted in driving the reform of an entire national public management system. The case is the Public Healthcare System of the Southern Italy in the period beginning in the early 1990s through the beginning of the new millennium, with particular emphasis on the Sicilian region, selected since it represents an extreme case of informal networks that affect organizational boundaries and governance functions.

This work is intended to contribute to the dialogue on the importance of informal network relationships in the public sector and the impact of managerial reform on these kinds of networks. Thus far, research on public management policy change does not seem to have adequately assessed the role played by informal relationships in halting such reform, in increasing the level of organizational inertia, or even in setting a parallel pattern of change ruled by the internal players. Three main reference fields crowd the academic archive on the subject.

First, we consider the literature on network management, which turns out to underestimate the "informal" component of these organizational constructs. Another reference field for understanding informal relationships in the public sector is managerial leadership, but it failed to provide the greater picture of a systemic phenomenon, being too focused on the heroic achievements of individual

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leaders. The third set of studies informing the research develops around the concept of ethics in the public sector. Instruments for fostering public ethics in the organizational culture play a major role in the process of managing the informal networks. Yet, one reason it does not provide a satisfactory framework for studying informal relationships in the public sector is that this specific kind of network sometimes acts in a sort of amoral or unethical fashion as a result of self-guidance and evolution. Observation and analysis of the Sicilian Healthcare System, indeed, show the mixed nature of illegitimacy on one hand, and efficient allocation of resources around centers of professional excellence on the other. Therefore, such complex and contradictory organizational cultures are not well assessed by merely looking at public ethics indicators. Further case-oriented research on informal networks in the public sector could tell us more about their functioning logic and mechanisms, and could tackle the problems connected to the implementation of managerial reform in public organizations governed by strong informal relationships.

The public governance paradigm, the focus of several public management studies in the recent years, has emphasized issues such as stakeholders mapping both internal and external to the public administration, and the identification of formal and informal networks which stem from the relationship among stakeholders (Kooiman & Eljassen, 1993). The analysis of public and private (both profit and non-profit) stakeholders, together with the evaluation of the governance mechanisms and interorganizational relationships play a major role in accounting for the successful implementation of public policies. Based on the study of multiple cases we tried to answer two main research questions related to the issue of informal networks within the public sector system as a whole and within the public sector organizations.

To present the work as a business history applied to the public management research field, we first differentiate the features of informal relationships from the features of formal relationships linking public administrations and businesses, such as lobbying, typically falling under the realm of business-government relationships research. Therefore, the first question is: *how to include the "informal" dimension in public management studies*? To approach this question one might consider the impact of such "informal" dimensions of the decision making process, on the connections between politicians and civil servants, on the managerial function, on the performance evaluation and on the progressive introduction of accountability principles in the public sector. Analysis of the healthcare system in Sicily allows one to understand the dynamics that brought the creation of the informal relationships, as well as to evaluate the impact of such informal relationships on the process of strategic and organizational change within the Local Healthcare Units. To answer the question stated above, we have to focus on how public

Table 1. From Public Management to Public Governance.

Environmental Dynamics	Government Role	Public Management Functions	Public Governance Main Problems
Complexity	Decomposition	Rapresentativeness	Global-Local
	Coordination	Selectiveness	Consistency
Diversity	Steering	Transparency	Quality
	Intervention	Legitimation	Individual
	weigthening		Preferences
Dynamism	Integration	Learning	Systems dynamics
	Regulation	Effectiveness	Scenarios

Source: Meneguzzo, 2003, based on Kooiman and van Vliet (1993).

management approaches can be enriched with new, loosely coupled management systems, aimed at governing, coordinating and guiding the informal networks (EFMD, 2001; Jann, 2001).

The second question is: *how to identify the strategies that public organization could and should enforce to leverage the positive impacts, and to control the vicious circles that informal relationships tend to create*? In order to address this question the option of applying new tools for governing and managing the network of informal relationships is considered. Such tools are linked to the new functions required by the introduction and the development of public governance principles, as stated by the "Dutch school" and presented in Table 1 (Kooiman & van Vliet, 1993; Meneguzzo, 2001).

As we present the events in our case, the spread of public governance principles as strategy for governing informal relationships in the healthcare organizations is assessed. Therefore, the third question addressed is: *how* can *the reinforcement of informal relationships among the internal players and the external stakeholders shape the strategic and organizational change of public healthcare organizations to create a better a mix between public organization features and professional organization features?*

To analyze the experience of the public healthcare system a "hybrid" methodology has been chosen. This is based both on the case study approach with a comparative perspective among the healthcare organizations of different local areas, and on the perspective business history approach with a 10-year time frame. Particularly, case-studies have been conducted with the support of the field-analysis, through the analysis of stakeholders, of their expectations and of the available resources (Rebora & Meneguzzo, 1990) and through the cognitive mapping. This work also took into account the policy implementation research field (http://www.inpuma.net). In Fig. 1 we sketch the narrative structure of the experience, according to a framework, introduced by Kingdon and adapted by Barzelay

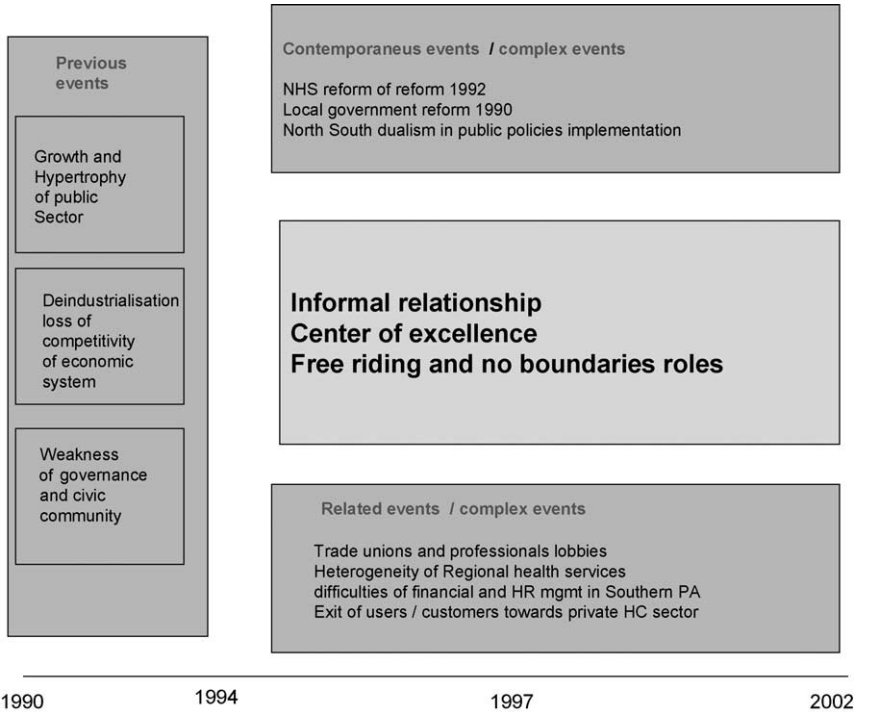

Fig. 1. Narrative Structure of the Experience Studied.

to public management policy change. The framework includes previous events, contemporaneous events and related events, during the time frame 1990–2000.

The following section is intended to provide a description of the events and the institutional features which preceded (previous events) or that proceeded at the same rate (contemporaneous events) as the main episode, mainly related to the Italian public sector reform, at the national and at the Regional level, often characterized by dramatic differences among Regions.

THEORETICAL FRAMEWORK: INSTITUTIONAL AND MANAGERIAL PERFORMANCE IN SOUTHERN ITALIAN PUBLIC ADMINISTRATION

Before considering the main events that determined the development of informal networks in the public sector, it is necessary to consider the reasons that lead to

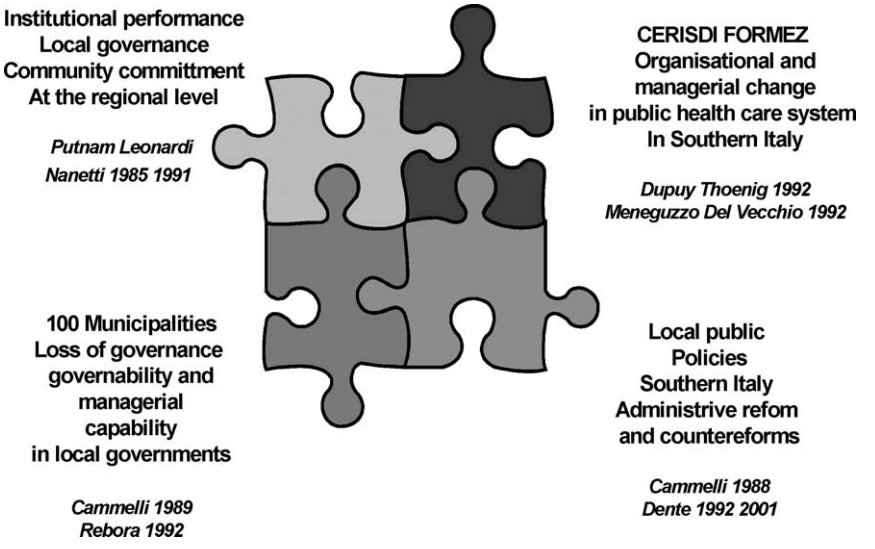

Fig. 2. Mosaic of Research on Public Governance and Management in Southern Italian Public Administration. *Source:* Authors, 2003 based on Putnam, Leonardi and Nanetti (1994).

our choice of the public healthcare system in Italy to define and illustrate our conceptual framework.

The choice of the public healthcare system in Sicily has to be framed in the mosaic of the research on the political, institutional and socio-economic context in Southern Italy. The context of Southern Italy presents peculiarities which can be adopted for interpreting phenomena such as the different speed of modernization processes in the public sector and the obstacles encountered in strengthening new public management and, more recently, public governance, principles. These features have been identified, as shown in Fig. 2, by the contribution of Putnam, Leonardi and Nanetti (1994), that investigated the conditions for creating strong, responsive, effective and representative institutions. These "longitudinal studies" conducted in 1970, 1976, 1981, 1989 on the Italian Regions were aimed at identifying the variables that could explain the regions' different institutional performance.

The research, emblematically termed "Governance and Civic Community," was conducted over a 20-year period through various methods, from direct interviews to political leaders and to the main interest groups, to case-studies of six target regions (ethno-methodological approach), and from the legal analysis and socio-economic planning analysis to the final users opinion poll. The Sicilian

case, compared with others of different regional healthcare systems, shows results far below the national average of the level of civic community, interpreted as a synthesis between governance ability, sense of ownership to the local community, and institutional and administrative performance of the regional public sector.

The structural weakness of governance and civic community is an element that preceded the consolidation of informal networks and the rise of free riding paths within the public healthcare system. Another piece of our research mosaic is provided by the studies conducted by Dente on local policies in Southern Italy. This work, on implementation tried to figure out whether there is a capacity differential in the policy implementation processes between Central and Northern regions vs. Southern Regions (Dente, 1992). Indicators of implementation abilities included the financial management of the local governments and of the local public enterprises, the personnel productivity of the local public administrations and the average length of the public procurement procedures. The research also included indicators of final-user oriented services, such as the water cycle, childrens' educational services and waste management.

Dente's conclusions pinpoint the North/South dualism in the political capacity for policy implementation. This may be explained by the lower presence and variety of networks, of a lower availability of information and knowledge management tools, and of a higher level of conflict between different players of the Southern regions compared to the North. Events we considered include North-South dualism in public policy implementation and the hindrances of financial and human resource management in Southern Italian public administrations. A third piece of the research mosaic emphasizes the importance of decision-making, managerial performances and quality of service in the local governments. Extremely interesting is the analysis of Rebora (1993) on the vicious circles that characterize local administration in Southern Italy. Our model was elaborated starting from the analysis of local government reactions in Southern Italy to the public administration reform initiatives that interested in the early 1990s. The model findings were also confirmed by research on the functioning mechanisms of the regional administrations in Sicily (Thoenig, Michaud & Dupuy, 1992). This model emphasizes the features of Southern regions, overwhelmed by administrative formalism and typically unable to detect the needs of their users and, more generally, of the preferences and behavior of various local socio-economic players.

This vicious circle results from the mix between rigid administrative models, only partially improved by the early 1990s reforms, and the social-cultural context they are embedded in, with a low perception of efficiency and productivity values. The prevalence of the tertiary sector, and, particularly, of the public tertiary sector – the main employers in most Southern Italian cities are the municipality and the

public hospitals – did not allow the development of professional resources and managerial skills from the industrial sector. In other words, the system missed opportunities for cross-fertilization among public sector, businesses and no profits (Thoenig, Michaud & Dupuy, 1992). This analysis shows a direct link between the growth of public sector coupled with processes of de-industrialization and a consistent decrease of local competitiveness, and other elements such as the diffusion of free riding in the local governments, the strengthening of professional and union lobbying, and, chiefly, the shift of users from the public sector to the private and the non profit sectors.

The modest quality of the delivered public services and the progressive weakening of public administration performance determined the migration of high-level targets of users, a threat that would normally push the administration to change. However, the rigid administrative culture, the scarcity of managerial and professional resources, the weakening of the mission in terms of production and of service towards the community, coupled with the raise of free-riding phenomena all resulted in administrative failure. Also, some players, external and, even more, internal to public administration in Southern Italy, promoted and managed a utilitarian approach to the use of public resources. By strengthening alliances and reciprocal protection agreements, these players enlarged the scope of control over recruitment and procurement. In this regard, the public healthcare system has been a laboratory for the development of free-riding practices, which in some cases led to positive results, such as the case of excellence centers.

Finally, the forth piece of our research design mosaic is the contribution of the CERISDI-FORMEZ[1] (1993) analysis of the features of the Sicily regional health-care system. As presented in the second section of the chapter, the findings of this research offer an interpretative model not limited to the public healthcare sector or to the case of a single region, but rather that can be generalized to help explain the differential in policy making, policy implementation and administrative capacity of the different Italian public administration systems at regional and local levels. From 1990 to 1992 CERISDI carried out a research project on benchmarking among the Italian regions, *de facto* divided into three sub-systems: Northern, Central and Southern regions. This research focused on the drivers of players and stakeholders, on the obstacles at the local level and on the organizational culture. The methodology included cognitive mapping. The research also focused on the systems of regulation, of functioning and of exchange at the local level.

The project was permanently subject to the auditing of an international scientific committee (see Annex 1) and different teams researched five issues:

- competition system and managerial behavior in the tourism sector;
- socio-economic development of industrial areas (e.g. the Catania industrial pole);

- organizational and managerial change in the local public healthcare sector (Sicily, Apulia and Abruzzo);
- competition system and managerial dynamics in the agriculture and food sector;
- organizational structure and functioning mechanisms of the Regional Directorate for European Union Relations.

The introduction of interpretative models on the functioning mechanisms and principles of the public healthcare system in Southern Italy must be framed with more general considerations. The case of the Sicilian healthcare system, its internal organization with an important role played by the informal actors and informal relations, might look at a first sight like an impenetrable micro-climate with its own equilibrium, rules, functioning mechanisms. Yet, we think its uniqueness should not dissuade us from a deepening the analysis, by framing the Sicilian experience in the ongoing debate about the impact of the administrative reform on the formal and informal relations of its sub-systems. To accomplish this end we considered:

- managerial leadership;
- ethics in the public sector;
- informal networking.

First, an aspect we take into account is the evolution of the role *of public entrepreneurs* and public managers, rethinking the interpretative model of entrepreneurship in government elaborated by Doig and Hargrove (1990). An important point made by this work is the concept of entrepreneurship as focused on turning new ideas into successful business ventures and that this model is *not* well suited to understanding the management challenges of large-scale public enterprise. This work recognizes the role of experimenting, but notes the bulk of the success factors are in the area of the difference of individual leaders in the evolution of substantial public programs over decades. The model conceptualized the role of political executives as entrepreneurs, depending on the two variables "managerial skills" and "commitment to program goals." The combination of low and high scores on the two variables gives birth to different profiles, from administrative survivors to generalist managers, from program zealots to program loyalists (Doig & Hargrove, 1990, pp. 47–67).

What seems to be lacking in the model is the ethical dimension, which should permeate and shape political executive action and also inform the commitment to program goals. The closest mention of ethics is the enthusiasm for the public program – but this downplays and simplifies the role of the ethical dimension.

Still, the value of the Doig and Hargrove approach is confirmed by an analysis by the research group CERISDI of the prevalence of hospital conflict between

administrative staff and physicians in Sicily (CERISDI FORMEZ, 1993). This analysis shows that the administrative staff performed bureaucratic management, worked according to logic of exchange in areas such as the recruitment or the systems of career advancement, and was held responsible for effectiveness of selected areas. Such behavior is common among "administrative survivors." On the other hand, the physicians traded a lower hierarchical position with the freedom of pursuing their own pet interests, such as exploiting professional opportunities in the private healthcare sector.

Additionally, the evolution of the concept of *public ethics* is critical to understanding our research approach. From Aristotle onward, thinkers have considered what is ethical, how does ethics relate to other aspects of life and whether there is only one ethic or ethical pluralism and relativism. These issues are part of our research particularly because we are interested in figuring out how to define public ethics according to specific features that conforms to "public" entities, as well as a way to translate public ethic principles into daily managerial decisions and actions of high level and street level bureaucrats in the Italian healthcare system.

This debate on ethics has a long tradition from Aristotle through the discussion of the role of the state and public officials in Locke and Kant, and has recently received a remarkable contribution by Dennis F. Thompson (1990). The main assumption of this work is that, ". . . the conflict between politics and ethics should not be understood in the conventional way: politics as a realm of pure power, governed by prudential prescriptions, and ethics as a realm of pure principle, ruled by moral imperatives" (1990, p. 27). This misconception would underestimate the complexity of our moral and political lives. Specifically, the issue of political ethics seems to be particularly relevant for our study, e.g. do public institutional ethics differ from personal and social group ethics?

There is one tradition of thought that casts the uniqueness of public official ethics, intrinsically linked to the political leadership, e.g. as detailed by Machiavelli. This conception, later modified and adopted by Weber, may be viewed as grounded in the claim that public official's decision making must be virtually beyond ethical limits (it may include the use of violent means) to achieve and enforce the public good. However, Thompson argues, ". . . the more typical moral choices of public officials are much less dramatic than the heroic tradition suggests" (Thompson, 1990, p. 29). The consequences of such demystification in the tautological definition of the character of political ethics turns out to be very relevant for the conceptual basis of this chapter. Public officials and their counterparts in private organizations spend most of the time making marginal choices among policies – typically with mixed moral intent and achieving only incremental change. In our view there should be no single system of ethics and there should be no protective aura around public officials' actions. We must link results and consequences to ethical responsibility.

Thompson notes that public ethical concerns include how we think and we act in relation to something called "the public good" (Thompson, 1990). The public good cannot be defined *a priori*, but must be measured in connection with how we negotiate it among all the other variables, leading to an intellectual and practical discipline that serves the *res publica*. Therefore, there is not one ethics recipe that can be replicated whenever needed, but rather we can adapt and adjust a broad range of intellectual and practical tools that give us the balanced mix of instruments for decision making and implementation. Thompson writes about criteria for making judgements, not particular rules or general theories, "... the criteria should be conceived as a set of factors that citizens as well as officials consider as they deliberate about decisions and policies" (Thompson, 1990). Our model tries to ground the need for accountability of public officials in terms of tools, whether based on education and training or on a system of incentives and punishments, which make public ethics something we can position through the logic of trade-off and of relative weight.

We have to acknowledge the dilemmas deriving from the representative character of the public office, which implies rights and obligations that ordinary citizenship does not share, or at least not to the same degree. The tension between the promotion of general values and of the distinctive values of official duties might not always be solved through a natural syncretistic solution, but rather may tend to identify professional duties as a top priority and, consequently, may cause violation of some "ought to be" shared moral principles. This problem inheres in the representative dimension of the public office known in Italy as "*dirty hands*." Moreover, *dirty hands* are often coupled with the problem of *many hands*, which pertains to the organizational dimension of public office, where players act together to support the decisions and policies of the government. The government can be thus perceived as a whole entity that does not allow ascribing moral responsibility only to the single official.

Finally, our methodology includes the concept of networks. The *network concept* in policy science research dates back at least to the early 1970s. In studies of the bottom-up approaches to management and in the intergovernmental relations literature (e.g. Scharpf et al., 1978), this concept has been used to map relational patterns between organizations to assess the impact of these patterns on policy processes. In these uses of the network approach to policy research, theoretical notions from the study of inter-organizational behavior are influential (Klijn, 1997). On one hand, the perspective builds on an interactive policy approach as an element of political science thought (e.g. Allison, 1971; Cohen, March & Olsen, 1972). On the other hand, insights from inter-organizational theory are applied (Aldrich, 1979; Levine & White, 1961).

The policy network approach focuses on the interactional processes between dependent actors and the complexity of objectives and strategies as a consequence of that interaction. An important element of such analysis is the context in which complex interactions about policy setting takes place. In an attempt to elaborate the institutional context of complex policy-related interactions, network experts have been inspired by the inter-organizational theory. A good example of the bottom-up approach may be found in implementation theory (Hjern & Porter, 1981). The point of the inter-organizational approach is that the environment of organizations consists of other organizations. To survive, an organization requires resources from other organizations, so there is an exchange process among players and a network of mutually dependent actors emerges. The theory gives substantial attention to the links between organizations and to the strategy to influence the exchange process (Aldrich & Whetten, 1981; Levine & White, 1961; Negandhi, 1975). Initially, the network approach was used to analyze complex policy processes in policy sectors (Rhodes, 1997; Wilks & Wright, 1987). In the 1990s, however, a number of new themes emerged in the network literature; including the notion that networks sometimes inhibit policy making while they also offer opportunities to facilitate policy making. This point is important for our study. The emphasis here is on the management of complex processes in networks (Kickert, Klijn & Koppenjan, 1997; Koppenjan, 1993). We give increased attention to the role of actor perceptions when explaining interactions taking place within a network, and we try to detect the influence of concepts grounded in organizational theory (Weick, 1979) and policy science (Rein & Schön, 1992). We draw on critiques of evaluation methods and criteria from a multi-actor perspective, and also investigate the concept of rule (Klijn, 1996; Ostrom, 1986; Ostrom, Gardner & Walker, 1994).

As noted, the network approach may assume that actors are often mutually dependent. Actors cannot achieve their objectives without resources owned by other actors. Interaction patterns among actors emerge around policy issues and resource clusters, and these patterns acquire a certain degree of sustainability because of the limited substitutiveness of resources. Thereby, rules are developed, regulating both actor behavior and resource distribution in the network. This also influences inter-network relations. Resource distribution and rules are gradually shaped through interactions (Giddens, 1984).

Thus, policy networks form a context within which actors act strategically and in which strategic action is confronted by the strategic actions of others. Series of policy-related interactions occur within the network. These series of interactions can be termed “games” (Crozier & Friedberg, 1980; Scharpf, 1997). The position of the players in the individual games is determined by their position in the network and by their strategic actions in the game. During the game, actors

operate within the limits of established resources distribution and sets of rules. In addition, they have to operate strategically to handle the given dependence in the game so that they can achieve their own objectives. During this action, they must interpret the existing rules, which typically are ambiguous.

Policy process can therefore be seen as complex games between actors. Each of the actors has their own perception of the nature of the problem, of the optimal solution and of the other actors in the network. They select their strategies based on these perceptions, so that the outcomes of the game are a consequence of the interactions among strategies set by the actors in the network. This concept is crucial to understand our case analysis.

THE SOUTHERN ITALIAN PUBLIC HEALTHCARE SYSTEM: MANAGERIAL REFORM AND ORGANIZATIONAL INERTIA

This part of the chapter defines the characteristics and critical aspects of the refrom of the local public healthcare systems in the Southern Italy – and specifically in Sicily, building on field research conducted in the early 1990s that was updated in the period 2001 to 2003. The field research work focused on the changes that preceded and accompanied the second National Healthcare Reform (1992–1993) in three regions of Southern Italy, namely Sicily, Apulia and Abruzzi. The transformation process in these regions has been compared to the process that took place in some Mid-Northern Italian regions, looking for a link between possible performance differentials and different structural features of the healthcare sub-systems.

Our research focuses on two complex events that represent the main episodes of reform that took place in environment of the public healthcare agencies analyzed in the past 15 years. First, to set the context, we consider the 1992 reform of the National Healthcare System and the reform of the local governments during the 1990s. Then, we lay out our critique of the effects and consequences of failure of reform implementation in the Southern Italian healthcare system. Finally, we relate the second complex event, the emergence of no boundary agents and systems, and provide conclusions about the effects of this phenomenon.

The First Event: National Health Care System and Its Effects

The first complex event was the 1992 Italian National Health System reform introduced corrective measures to the previous reform that, in the late 1970s, established

the NHS. The most relevant changes introduced by the 1992 law were the shift from local healthcare units (LHU) to local health agencies, resembling establishment of the Community and Hospital Trust in the United Kingdom NHS, and the empowerment of the Italian Regional governments in the healthcare sector, a move in reversal of the traditional, highly centralized Italian health system.

Before this reform, the 674 local healthcare units were highly complex organizations, due to the different services and markets they were asked to serve, from community care and GPs to tertiary care. Organizational complexity was also given due to the decentralization of the supply structure and, consequently, the service network, and can also be ascribed to the need for balancing clinical autonomy of the staff (typically the physicians) and the organizational rules of the firm. An example is demonstrated by one figure: among the 600,000 employees of the local healthcare units, 100,000 were physicians.

These elements were complicated by patterns of functioning mechanisms common to the Italian public organizations, such as the prevalence of formal rules over quality and results-based management, to the lack of managerial skills and tools, e.g. strategic and economic planning, human resources management, information systems. Among the expectations that the shift from local healthcare units to local healthcare agencies raised, is the reduction of complexity in the healthcare services supply policies. This was expected to work by focusing the activities of the 200 newly established local healthcare agencies (LHA) on core activities such as community care and outpatient services. In fact, the 200 new hospitals, resulting from the merging and downsizing of the healthcare agencies, ended up focusing on inpatient services – but this is only a small part of the story of reform consequences.

The reduction of the executives' roles and the introduction of one CEO, together with the elimination of governmental representatives and local lobbies as a result of the reform of the 1990s was a further element of the simplification of the complex decision-making and organizational structure of the LHUs resulting from the 1970s reforms. It is interesting to note that in the cases analyzed, the introduction of NPM principles in the 1980s and early 1990s did not exert a decisive push on the first complex event – the development of informal networks. Rather, as we demonstrate, such networks resulted from the combined effects of the weak external cohesion and the lack of dynamics that would reinforce internal cohesion.

Given this framework, the research sought to identify the critical variables that assured cohesion in the whole system, comparing Sicily to Northern region LHUs. These cohesion forces are related to policies of the Regional governments and the local authorities, to the behavior of the final users of the medical services, to the strategies of the private competitors and the local governments. On the other hand, the internal cohesion forces concerned the relations between managerial

and physician parties, and the strategies put in place by the internal local subjects. The full research methodology and case study is not presented here due to space limitations. What follows are the conclusions based on the case analysis that included the study of both public and private health care facilities and the network relationships throughout the entire healthcare system.

Characteristics of the Southern Italian System: A Synopsis of Conclusions

Analysis of the Sicilian relationship system shows the structural weakness of what were supposed to be cohesive elements. First, the regional Authority does not use self-government and discretion according to healthcare system reform intent, and as a result ascribes the regional institutional level a leading and central planning role. The regional level is not performing that role in a proactive way, stimulating organizational and managerial innovation at the local level, nor at the central level, through a Regional Healthcare Program or a general development project. A critical element of the reformed system was supposed to be the participation of private healthcare providers.

The study of private healthcare reveals a highly concentrated system (50% of hospital beds located in metropolitan areas) providing non-specialized services in a system characterized by:

- The prevalence of family-type businesses that disregard development strategies at the corporate level (e.g. evaluation of make or buy strategies, strategic human resources management);
- The failure to appreciate organizational investments, confiding in the acquired competitive advantage, concerning mostly side aspects of the service (comfort, queues);
- The search for cooperative positions with the public healthcare system through the possibility of financing by the public healthcare system for services provided to citizens by the private structures;
- A lack of entrepreneurship, and low levels of risk taking, coping with greater attention paid to short term return on investment.

Therefore, the private healthcare system does not play the part of a "real" competitor to the public sector, *nor* the part of a synergistic partner in the development of services. What has resulted is an autarchic and collusive (between public and private) system – an almost perfect ecosystem for the development of informal networks.

The study of the healthcare system users showed a remarkable difference in the attitudes of Sicilian and North Italian citizens, mainly regarding expectations of public service and the capability to put up models and mechanisms of representing organizations (advocacy associations). Regarding Sicily, the public service was

seen more as a favor or a special consideration of the public organization and less the due satisfaction of a need.

On the other hand, the Sicilian public healthcare organization didn't activate any complaints or information services to citizens or quality improvement projects, started in the early 1990s in most Italian regions (with Citizen Charters, and URP – an institutional communications and marketing specialized unit). Finally, the local authorities (Municipalities and districts/prefectures) contributed to the weakness of the healthcare system. The politically elected bodies are surely interested at building consensus; anyway this depends more on the ability to acquire resources (financing new infrastructures, hiring new staff) and less with the performances.

These dynamics are extremely relevant considering that, in the same time-frame, local government reform had been launched. This reform was aimed at reinforcing strategic, organizational and managerial capacities of provinces and municipalities, as well as at introducing New Public Management approaches, from managerial control to the diffusion of contracting out, contracting in and public private partnership.

The weakness of the external cohesion led the Local Healthcare Agencies to become no boundaries public organizations, characterized by a relationship system that doesn't promotes the development of a coherent institutional environment that halts the momentum of the healthcare agencies change process. On the opposite end, the diverging interests of the actors and the lack of regulatory mechanisms (performance accountability, co-interest of the actors on the quality, evaluation and penalization systems) represented a barrier to innovation and modernization. Furthermore, the lack of converging interests of institutional subjects is coping with strong "centrifuge pressures" inside the organizations.

The lack of internal cohesion concerns, the prevailing centrality of the administrative part of the organization, and the simultaneous weakness of the medical direction all were problems to be faced. It is not, however, the necessary contraposition found in every healthcare organization between administrative attitudes (obey to the norm and formal procedures) and professional ones (clinical autonomy, discretion research, maximization of the resources available). What distinguishes the Sicilian healthcare system is the possibility for the administrative staff to act as a single and powerful gatekeeper of resources in terms of hiring new staff, supervising times and ways of goods and services procurement, and controlling available spending.

Given the extent of the power of the administrative party, the roles of physicians could be "fine-tuned" by administrators in three different ways, accepting, in a first case, a low-level management, without exercising pressure over the administrative sector. In the second option the administrative staff could contract with the physicians the exercise of some flexible interpretation of the rules; this allows the

employment of a strong organizational power, finding solutions to problems. In the third option physicians are equipped with the necessary skills and competencies to be self-sufficient without the support of the administrative department.

The centrality of administrative attitudes found in the Sicilian context is strengthened by the external environment with a weak governance role of region and the lack of pressures required for the improvement of the service's quality from local authorities, citizens and private health sector. Besides conflicts between healthcare professionals and administrative bureaucracy, managerial weakness determined an extremely low level of internal cohesion.

The Second Complex Event: Absence of Boundaries and Resultant Effects

The second complex event is the devolution of Italian Healthcare system that resulted from the implementation, over a ten-year period, of important elements of the comprehensive national reforms of the early 1990s. We characterize this event as the development of what we term "no boundaries" public organization that took place in selected public healthcare organizations as one result of the national reforms. A critical part of this story is the emergence and spread of "no boundaries" civil servants. These individuals are subjects inside healthcare organizations that serve important roles in other systems: in the local political system, in trade unions, in private healthcare organizations, in firms supplying goods and services.

These border roles increase the "centrifuge pressures" and the fragmentation of the public healthcare organization (resulting in many sub-organizations and sub-relationship networks carrying special and different interests). However, in some instances, these border subjects are the most dynamic parts of the organization, as they have managerial skills and can employ resources coming from different systems. In presence of organizational weakness, free rider behavior becomes stronger.

Thus, we find examples of chief physicians that increase the medical staff through their trade union membership or other services that have privileged access to technological equipment and are able to develop high specialties in a self-managerial way. These behaviors arise due to the inability to control and contrast the "centrifuge pressures."

Anomalies and Excellence Centers in the Sicilian Public Healthcare System

As mentioned, the presence of a weak institutional context promotes the rise of new managerial forms and the creation of excellence practices. Again, this is about a complex event observed in many realities mutually influenced by informal networks and free riding elements. There are many levels of intervention that

may explain the development of excellence centers in the weak Sicilian healthcare system, including the following:

(1) The capacity to limit the growth of new specialist services inside the hospital to contain the fragmentation pressures and the operative overload; this allows a progressive improvement of the existing medical special fields of activities;
(2) A decrease of the administrative power through the direct assumption of some key functions (equipment procurement process, the management of investment funds, contracting out) by the medical direction; the management procedures performed directly by the medical director, avoided the dependence from the administrative services;
(3) The choice to keep the hospital out of the integration process with other hospitals and local healthcare systems; the CEO was able to limit the interference of local political forces, conserving the institutional and organizational autonomy of the hospital;
(4) The support and promotion of excellence specialized centers inside the hospital, favoring the direct involvement of the physician chief department; instead of limiting managerial autonomy of the physicians, the medical direction has chosen to strengthen hospital power vs. the regional council;
(5) The University's link, organizing seminars and updating the physicians' knowledge, also reinforces their professional identity and improves the hospital's image both inside and outside the local context.

The building of excellence centers indicates how discretion in an informal relationship, combined with the fragmented power of free riders, can result in innovation. The leadership and managerial capacity of the medical system allowed a self-managed and self-organized development of hospitals, in clear contrast with a general non-innovative context.

Our research found other managerial practices that stimulated excellence islands inside the Sicilian healthcare system (e.g. in the Captain and Palermo Hospitals). Common features may be observed in these centers. First, there is the presence of relevant inter-institutional relationships created by single physicians, acting as border role agents. The unit responsible tries to build its own relationship network that goes well beyond the institutional boards of the public healthcare organization, maximizing the free-riding opportunities allowed by the environment. Also accelerated development processes, by knowing how to acquire additional resources, faster and easier than in the traditional procedures (new staff and equipment), and by promoting a virtuous circle with new access to resources. This led to greater development capacity of the units to the detriment of the other medical services, which got less competitive.

Finally, the development of excellence centers does not bring a diffusion of innovation or an emulation process, leading to a general growth of the organization. To the contrary, a passive attitude, not competing for resources and not innovation-oriented, of the other services is highlighted. This is why the excellence units do not find obstacles to their development inside the organization. On the external side, their success depends upon their capacity to build inter-institutional relations that promote access to resources through strategic interlocutors activated on an *ad hoc* basis.

Organization, Network Relationships, Behavior and Innovation

The study of the Sicilian healthcare system in the early 1990s and of the complex events noted leads to some general conclusions concerning the relation between organization features and actor behavior on one hand, and innovation in the development of modernization processes on the other.

The first consideration is the centrality of rent seeking in the context analyzed. The absence of the market and of competitive mechanisms implies for most of the actors the exploitation of present opportunities at the detriment of risk taking. The administrative staff prefers maximizing the discretionary interpretation of norms instead of reorienting its own role and functions to a managerial perspective. The private healthcare system prefers using its competitive edge on the public organization through collusive agreements instead of implementing development processes in the medium term.

Politicians and institutions prefer consensus building on the resources supplied to the system to the detriment of consensus on results. The medical staff employees their own relationship networks instead of becoming part of the organizational development model. In all cases, even the more entrepreneurial ones, individual action and rent seeking prevail on the capacity to implement collective action and development plans.

The institutional mechanisms meant to reduce uncertainty and promote transparency is weak; possible bottom up innovations does not find a structurally prepared system to receive and protect them. This system does not promote entrepreneurial behavior and risk taking. Individuals decode the context on the basis of their own personal standards and experience. Rent seeking is strongly correlated to the way actors consider risks and opportunities. In other words, rent seeking is a way to react to future uncertainty.

The consequence of this process is the progressive lowering of development and efficiency and economic rationale research levels. A systemic economic rationality prevails, coherent with a sub-optimal, strongly inertial development model. In

such a system, modernization costs are far higher and time to development much longer. Such a phenomenon is determined by the establishment of behavioral paths that have worked in the past, not searching alternative solutions, even when they should be better referring to costs or quality of the public service.

Third, all processes analyzed evolved through increased fragmentation and a difficult transition to unique model. Who manages the fragmented system? The question is clearly provocative, because the answer is that only the system can manage itself. However, in the case of a system characterized by "centrifugal pressures" and a plurality of external relationship networks driven by diverging interests, any local action tends to reinforce the fragmentation instead of recomposing it. Finally, a system that resists change produces very evident negative externalities and higher implementation costs for the whole society.

CONCLUSIONS: FROM INFORMAL NETWORKS TO NETWORK MANAGEMENT

This concluding section attempts to answer the three questions initially posed in this chapter on how the reinforcement of informal relationships among the internal players and external stakeholders can shape the strategic and organizational reform of public healthcare organizations.

To recapitulate, our first question was: *how to include the "informal" dimension in public management studies*? We have addressed this question by the manner in which we have analyzed the Italian healthcare system in this chapter. Informal variables have been shown to be important to reform. The second question was: *how to identify the strategies that public organization could and should enforce to leverage the positive impacts, and to control the vicious circles that informal relationships tend to create*? The third question was: *how can the reinforcement of informal relationships among the internal players and the external stakeholders shape the strategic and organizational change of public healthcare organizations to create a better mix between public organization features and professional organization features?* We now attempt to answer questions two and three. Also considered in this section is how the introduction and development of new public management approaches attenuated the differences between two main categories of informal relationship, the no-boundaries organizations and the excellence centers.

To address these questions we rely on research reporting the evolution of Italian healthcare systems over a 10-year time frame, concentrating on the Southern Italian healthcare organization case studies initially analyzed by the CERISDI research initiative (1993). We begin by addressing lessons learned from analysis

of excellence centers in the Southern Italian healthcare sector, and at the local healthcare agencies that we have characterized as no-boundaries organizations.

Lessons from the Evolution of Excellence Centers

The sixty local healthcare units (of the ninety in existence at the beginning of the reform period) were reduced through the decade of the 1990s to nine macro-healthcare enterprises operating in wider areas defined as *Province* territory. The mergers strengthened the balkanization process, with the passage from LHUs to macro LHAs (Local Healthcare agencies). By receiving staff, hospital and territorial structures from the previous LHUs, such enlarged organizations are forced to face a greater complexity. The excellence centers had completely different development trajectories. For example, the Cervello Hospital in cooperation with the Medical Center of Pittsburgh University started a partnership in 2000 for creating the Mediterranean Institute for Transplant and High Specialization Therapies, which became a pilot project of the Italian National Healthcare System (see the www.ismett.edu).

To understand the links between the reform – the nationally mandated new public management approach of devolution that drove the reforms beginning in the early 1990s – and emergent informal relationships in the Italian healthcare system, we focus on the roles of public leaders and managers based on degree of conformance to a model of entrepreneurship in government. Cross-border roles, no-boundaries organizations and balkanization of the public healthcare administrations – well-known phenomena of the 1990s – created a weakened institutional commitment, and complicated the identification of "zealots" and public program "loyalists" role players. The concentration of zealot and loyalist camps seemed to increase due in great part to the balkanization of the health care system. In summary, we found that the Southern Italian healthcare system to be dominated by characteristic regional organizational values, without much direction and managerial skills, strongly influenced by inter-institutional network management, the socio-political-institutional environment and procedural constraints (see Fig. 3).

Survival is a major value in Southern Italian bureaucratic culture to the extent that administrators/managers are not very interested in taking on cross-border roles. However, they have been positively influenced by the role models of the professional bureaucrats responsible for excellence centers, who generally operate autonomously from the LHAs organization, and the "burogattopardi," who are able to balance the different free-riding strategies, both ones with positive and those with negative impacts on the organization.

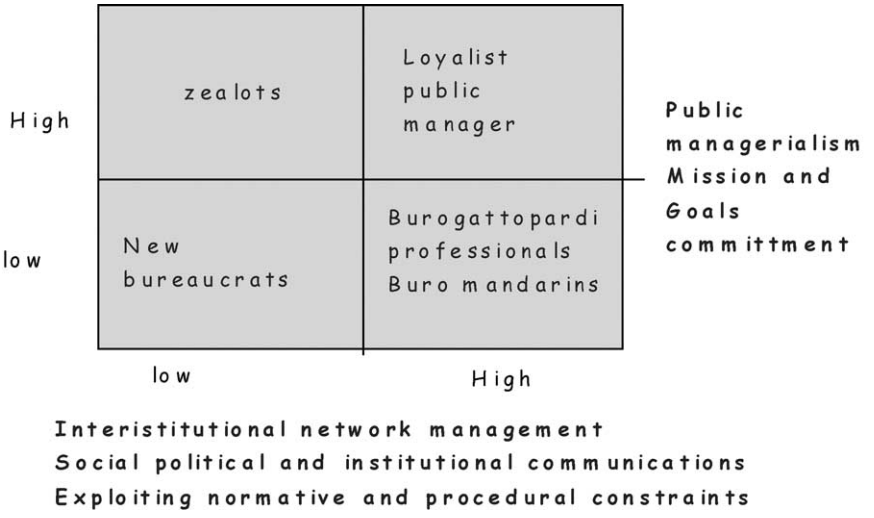

Fig. 3. Typologies of Managers and Professionals in Public Health Care Organizations. *Source:* Authors, 2003.

Based upon our analysis of case studies we also found that an important contribution to public management and public administration studies may be made through better understanding of informal networks by:

- a more accurate definition of leadership and management roles;
- identification of the relationships between leadership/management roles on one hand and interorganizational/intraorganizational networks on the other.

Another fundamental issue we assessed is how to build and maintain inter-institutional relations to ensure the success of excellence centers through the exploitation of the free-rider behavior and the continuing re-definition of public administration boundaries. The roles of the different players could be structured to facilitate the design and execution of strategies emphasizing the introduction of new public management approaches. Identification of the context and content of such strategies is directly linked to answering the second question posed in this work on the alternatives that might be enforced to exploit potential networking advantages while still governing carefully the critical parts of these informal networks.

One strategy to accomplish the task noted has been to act through managerial re-qualification of public healthcare organizations aimed at increasing the level of internal cohesion and progressively transforming the LHAs into more participative and "unitarian" type organizations. This strategy has required as primary leverage the involvement of what we have termed "zealots" (middle management at the

administrative and medical levels) as public managers who "sell" and push reform of the managerial culture and systems while attempting to influence the delimitation of organizational boundaries. Extensive managerial training and ICT development are connected to this strategy. Despite the apparent attractiveness of this strategy, after ten years of trying, this approach has not seemed to work very well in our view.

Case studies show this strategy has induced different dynamics than intended. In local healthcare agencies interested in the merging/networking, and in creating no-boundaries status (Del Vecchio & Cantù Lega, 2001) to exploit the weaknesses of the existing managerial culture that resists change, zealots have interfered with innovation. Some organizations, such as Palermo Polyclinic (a university hospital), have succeeded as no-boundaries organizations despite the presence of selected zealots, through *ad hoc* use of managerial leverage. Such cases are interesting due to their high complexity in terms of functions carried out by their organizations (traditional hospital services plus university training and research), in organizational structure (12 departments including childcare, oncology, neurology and psychiatry, surgery and transplants) and in terms of internal stakeholder membership and participation (e.g. medical and academic professionals).

The no boundary strategy has focused on investing in internal "excellence islands," adopting new managerial systems, and outsourcing ancillary services including those for biomedical technologies. In addition, there was an openness to increased institutional fundraising and creating public/private partnerships to fund information and communication technology and emergency services. The excellence centers made instrumental use of such innovative arrangements to consolidate their position with regards to regional authority and the others institutional stakeholders so as to achieve greater autonomy and control over strategy setting.

Another strategy we identified has focused on the roles played by the mandarins, named here as "burogattopardi." Through their roles as professional bureaucrats, they have operated successfully in applying neo-managerial logic in institutional re-building and organization restructuring, and by exploiting the network management. New managerial systems and the development of new paradigms of public governance, as well as the integration of different cultures and reference disciplines (e.g. human resource management, ethics, philosophy, managerial sciences, economics and law) are illustrative of this second strategy, which indeed is more consistent with the demands of the Italian bureaucratic environment.

Coherence between this second strategy and the context conditions is witnessed in the fact that the primary agencies and managerial training organizations in Southern Italy openly refer to managerial models inspired by network management and network governance (e.g. in CERISDI; ISIDA of Palermo and the Sicilian High Regional School for the Healthcare Sector). This strategy is highly

consistent with the dynamics encountered in the NPM-oriented modernization processes operating in the Italian public sector. Indeed, Italy represents an interesting experience in the international panorama in terms of obstacles to implementation of NPM principles through National guidelines. Our success stories of innovation diffusion were found most frequently in local government administrations, and to some extent in the National Healthcare Service.

Thus far, the issues of "innovation-by-law" and of bottom-up managerial reform have been the main themes of NPM research in Italy (Borgonovi & Meneguzzo, 1997). However, this research has not yet fully investigated the issue of the "three Italies," the "one hundred cities" and "North-South administrative dualism." All these cultural and related phenomena reveal great differences in terms of culture, functioning mechanisms and institutional performance of Italian public organizations. So, NPM research may be off to a good start but it has a long way to go to demonstrate significant results.

An evolution cycle of these trends appears to be taking place in Italy with passage from new public management logic to greater emphasis on increasing the capability and integrity of public governance systems, as well as the establishment in numerous local areas not just of better managerial leadership, but also of public entrepreneurship. Such changes have promoted and sustained innovation both in public services delivery and in process management. Moreover, this kind of leadership has succeeded in attracting more external players, such as those from the private sector and third sectors. This and the other strategies reported above provide evidence to answer in part the second and third questions posed in this study.

Finally, what have we found in our examination of cases and strategies regarding ethics in the public sector? The theory of political ethics recognizes the difficulties of identifying individual responsibility for duties exercised for others and with others. We have moved beyond the individualistic definition of ethical responsibility towards a network definition. We found that some network activities appear to break ethical norms by "going around" the established healthcare bureaucracy. Indeed, some successful entrepreneurs also violate social and organizational norms and sometimes even the law to achieve innovation. It seems clear to us based on our research that neither the national nor other levels of government, through the ever-present system of checks and balances, nor the citizens through their monitorial power, can dictate ethics for public healthcare officials. Rather, and this is essentially what we claim for the Sicily healthcare system, ". . . they should be held responsible for some decisions and policies that result from defective structures, not only those they could have corrected but also some of those that they could not have corrected" (Thompson, 1990, p. 47).

Where ethical standards have been violated, managers should be held accountable. If results are negative, responsibility and blame may be assigned to managers

and proper sanctions applied. However, if the results of entrepreneurship are positive then who is to complain beyond those gatekeepers responsible for maintaining the traditional rule-oriented culture? Citizens want better and more services. Service providers want better production attributes, better service to citizens and private benefits, e.g. jobs and income. If these are obtained then the provider community will not complain. They care little about the rules or bureaucratic ethics. However, one problem remains. When networks engage in unethical behavior, who may be held accountable? The easy answer is all of the participants in the network. In reality, this simply does not occur. The characteristics of networks allow virtually all participants to avoid accountability in one way or another. Thus, here we have an area that deserves greater public scrutiny and increased public management research attention.

NOTE

1. In the late 1980s FORMEZ was launched as an operative agency of the Central government with the precise mission of ensuring a professional and permanent training for the Southern public administrations. FORMEZ developed three "excellence schools" of managerial training in the three Southern main metropolitan areas: Naples, Bari and Palermo. CERISDI developed a training program by integrating models of managerial education addressed to business and to the public sector, and by spreading a managerial culture among leaders, in order to enable them to effectively deal with socio-economic environment in which they were embedded.

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REFERENCES

CERISDI FORMEZ (1993). *Un modello pedagogico formativo per lo sviluppo manageriale*. Palermo: CERISDI.

Dente, B. (1992). Le politiche locali nel mezzogiorno: Modelli di legittimazione e meccanismi di policy making. Istituto per la ricerca sociale.

Doig, J. W., & Hargrove, E. C. (1990). *Leadership and innovation: Entrepreneurship in government*. John Hopkins Univesity Press.

European Foundation for Management Development: Managing for good governance in the public sector. 16th annual public sector conference Milano 2001.

Jann, W. (2001). *Governance: An issue for Germany*. Potsdam University.

Kickert, W. J. M. et al. (1997). *Managing complex networks*. London: Sage.

Kooiman, J., & van Vliet, M. (1993). Governance and public management. In: K. A. Eljassen & J. Kooiman (Eds), *Managing Public Organizations: Lessons from Contmporary European Experience*. London: Sage.

Meneguzzo, M. (a cura di) (2001). *I network nel settore pubblico*. Milano: EGEA.

Putnam, R., Leonardi, A., & Nanetti, R. Y. (1994). *Making democracy work: Civic traditions in modern Italy*. Princeton University Press.

Rhodes, R. A. W. (1997). *Understanding governance*. Open University Press.

Thompson, D. F. (1990). *Political ethics and public office*. Cambridge, MA: Harvard University Press.