International Public Policy Association
International Conference on Public Policy
ICPP 3 - Singapore 28-30 June 2017
http://www.ippapublicpolicy.org/conference/icpp-3-singapore-2017/7

PANEL T03P11 – BRINGING POLITICS TO THE ANALYSIS OF PERFORMANCE MEASUREMENT PROGRAMS: CASE AND COMPARATIVE STUDIES IN HEALTH POLICY

Topic T03: Policy and Politics sponsored by Policy and Politics Journal

CO-ORGANIZERS AND CHAIRS

Panel Chair: Fabiana C. Saddi, Federal University of Goias – Brazil fasaddi@ufg.br ; fabianasaddi1@gmail.com

Panel Second Chair: Nick Turnbull, University of Manchester, UK - nick.turnbull@manchester.ac.uk

Co-organizer: Stephen Peckham, London School of Hygiene and Tropical Medicine and University of Kent, UK s.peckham@kent.ac.uk

Co-organizer: Matthew J. Harris, Imperial College London, UK - m.harris@imperial.ac.uk

SUMMARY

OBJECTIVES AND SCIENTIFIC RELEVANCE OF THE PANEL

The objective is to gather political-realistic studies focusing on either or both policymaking and implementation processes of performance measurement (PM) programs in health policy in developed and/or developing counties, as a case or comparative study.

PM programs have been adopted in countries with distinct levels of development, and tend to continue to play an important role in policymaking. In this process, the adoption of PM has revealed some challenges during implementation and has therefore, though in different rhythm between countries, been accompanied by the valorization of political-realistic or more post-positivist type of analyses. Those programs are constructed and implemented in political and social environments with distinct organizational capacity and where people hold values and interests that can influence the implementation of rational-based PM programs. This is why concerns based on who are involved in its elaboration and implementation, as well as on where/how those processes have been realized, have recently contributed to enhance the importance of taking the politics, the cognitive/subjective ("alternative logics") and work task and organizational aspects of PM programs into account. They have also contributed to better understand and unfold some dynamics and regularities that go beyond rational-based concerns. This literature emphasizes aspects such as political system, organizational culture, participation of staff in the implementation, appropriateness of the design, the possibilities of gaming (Bevan and Hood) and cheating and symbolic uses. Also, concerns and consequences regarding performance measurement programs have been categorized as "performance alternative logics" (Pollitt), as the "politics of performance" (Lewis) and as "performance paradox", as examples.

When applied to middle and low income countries, studies have given emphases not only to front line staff's involvement (Songstad et al.) (Chimhutu et al.) (Ssengooba F et al.), but especially to organizational constraints (Olafsdottir et al.), given the fact that the policies still face some contradictory organizational problems (Saddi and Harris et al.). Those works are considered important for having enhanced the knowledge on motivation and impact regarding front line workers in contradictory or problematic contexts, as well as for shedding lights on how to enable the creation of a

culture of evaluation in diverse and not always favorable organizational and political environments.

From the policy diffusion perspective, however, we still know little comparatively about the distinctive and politically significant challenges involved in the implementation of PM programs not only across health unities with different configurations in each country, but also across countries with distinctive and similar levels of development.

If those issues constitute a significant lacuna in the knowledge of comparative health policy and politics, shouldn't we develop comparative political analyses evaluating how PM have been designed and implemented? What methods could be used to develop meaningful comparisons across countries, taking each reality into account? Could differences be explained in terms of institutional heritages, or by means of using a comprehensive and long-term political analysis? What lessons could be partially and meaningfully transferred from developed to developing countries and vice versa?

CALL FOR PAPERS

This panel welcomes papers focusing on either or both the policymaking and implementation process(es) of performance measurement programs (PM) adopted in health policy in distinct countries in the last years. We expect papers to take into account the actors, ideas and interests involved in the policymaking and/or implementation phases in diverse institutional setting(s) and macro/micro political context(s). Papers can be applied to either primary health care or specialized health care policies. Analyses should focus on political or political-realistic aspects of policy-making and/or implementation processes, or establish politically significant relationships between both processes. We welcome studies that consider policymaking from the view point of social learning (Hall), policy transfer (Dunlop), feedback (Jacobs), policy regime change (May), state capacity, performance regimes and system of performance (Talbot) and/or as communicative practice (Fischer) (Turnbull) or from other interactive perspective. Implementation analyses that have applied surveys, semi-structured and open interviews, as well as developed focus groups or policy dialogues with front line health workers are highly encouraged. Papers highlighting the inherent problems of measuring performance in health care delivery when comparing those interventions where the medical intervention and professional practice has only a partial effect and where self-care and informal care may play a larger role in success (Peckham) are welcome. Country analyses of PM programs and comparisons across countries employing mixed-methods, qualitative and long-term analyses, as well as political-sociological and institutional type of policy analyses will also be considered. Papers that deal with the theme of this panel in innovative and politically and policy relevant ways will be highly appreciated.

Co-organizers and chairs: **Fabiana C. Saddi** (Federal University of Goias, Brazil), **Stephen Peckham** (London School of Hygiene and Tropical Medicine and University of Kent), **Nick Turnbull** (University of Manchester), **Matthew J. Harris** (Imperial College London).

Deadline for PAPER Proposals: 15th January 2017

List of panels: http://www.ippapublicpolicy.org/conference/icpp-3-singapore-2017/panel-list/7

PAPERS SELECTED (TO BE SOON DISTRIBUTED IN TWO SESSIONS)

PAPER 1: THE REASONS BEHIND THE RAPID EXPANSION OF PERFORMANCE-BASED FINANCING IN THE HEALTH SECTOR IN SUB-SAHARAN AFRICAN COUNTRIES: THE EXAMPLE OF CAMEROON

Author : Pierre ABOMO - Ph.D. Candidate in Political Sociology Université Paris 1 Pantheon-Sorbonne, France - abomokele@yahoo.fr

ABSTRACT

Background:

In order to speed up the process of reaching the Millennium Development goals (MDGs) by 2015, a new instrument known as Performance-Based Financing (PBF) was introduced in many African countries to reform health systems. This new instrument, also known as Pay for Performance in developed nations such as the United States of America and Great Britain, is the product of the philosophy of New Public Management which has been the dominant approach in the reform of public administrations around the globe since its inception in the 1980s when it was championed by Margaret Thatcher and Ronald Reagan. In Sub-Saharan Africa, PBF was initially introduced in Rwanda in 2006 as a tool to reform the health system and improve results. Since then, the tool has been expanding quite rapidly in almost all Sub-Saharan African countries. For mainstream analysis, this rapid expansion could be explained as the result of the successes that it has achieved in reforming health systems, changing behavior and introducing a new managerial culture. However, new findings show that, if undoubtedly there is a warm welcome of PBF among health workers, this is not the main reason of its international diffusion. So, the purpose of this paper is to investigate these other reasons behind the enthusiasm around PBF in Sub-Saharan Africa.

Research question:

This paper is designed around the following research question: What are the reasons that could explain the positive perception of PBF among health workers and experts?

Methods:

The research is based on a political science approach and qualitative methods. The design of the research is around the example of Cameroon where I conducted a field work in two health districts. Cameroon is taking here as case study to exemplify the trend across the region. The selection of the two health districts was made on purpose. Indeed, since 2012 the health districts selected have been part of a pilot

program to experiment performance-based financing in Cameroon. Information was collected through observation and semi-directive interviews supported by an interview guide.

Research findings:

The apparent success and positive perception of performance-based financing from health workers could be explained by two main findings: firstly, there are institutional and ideological reasons explaining the international diffusion of PBF from developed to developing countries; secondly, there is a socio-economic and administrative context allowing the acceptance of this reform despite its limited results so far. Indeed, PBF has generated additional income for health workers and experts who have experienced decades of massive salary reductions imposed by budgetary constraints since the 1990s. Also, PBF is perceived as a decentralization method that allows managers of health facilities to have more power and room to maneuver. However, all the above reasons tell nothing about the effectiveness, efficiency and sustainability of performance-based financing to reform health system. Many findings show that in terms of impact, there are still more questions than answers.

PAPER 2: DELIVERY AND MANAGEMENT OF FUNDS FOR A NATIONAL HIV HEALTH PROGRAMME IN SOUTH AFRICA

Author : Gavin Surgey - Senior Research Fellow at Health Economics and AIDS Research Division (HEARD), University of KwaZulu Natal, South Africa - gsurgey@gmail.com

ABSTRACT

Background:

In South Africa, the main source of funding for HIV programmes implemented by Department of Health is the HIV and AIDS Conditional Grant initiated under the Division of Revenue Act. These funds ensure the rollout of programmes or projects that are of national importance and require a coordinated response.

Research Question

What is a good mechanism of delivering funds to address health Issues on a large scale and monitoring the implementation progress? How does an allocation and monitoring process work when delivering services where there is disease burden of epidemic proportion and what are some implications of the interwoven politics behind the allocation of funding?

The paper will also consider:

· How the use of relatively easily measurable quantitative performance measures, such as numbers of persons on antiretroviral treatment, tends to dominate or replace indicators which are more difficult to measure, such as for gender-based violence, human rights and behavior change. This aspect of performance assessment tends

to reinforce and reward budget allocations towards bio-medical as opposed to behavioural interventions

· How the use of specific performance measures tends to incentivize performance in the areas of the selected indicators, with less attention being given to the areas that are not being measured. Again this tends to reward a small number of measurable biomedical interventions.

· How performance measures are gamed, for example, in attribution, measurement and reporting

· How performance auditing which is supposed to be improving quality of performance data has at times had perverse effects including departments greatly reducing numbers of indicators, removing challenging targets and refocussing on easy-to-measure process indicators as opposed to outcome indicators

· How the use of departmental performance reporting, while of immense importance, tends to reinforce interventions that have benefits within single sectors, rather than summating benefit across several sectors. Put differently interventions that may not appear worthwhile funding from an individual sector's perspective may be when combined effects across several sectors are considered.

Methodology:

Analysis is based on the South African health system where an estimated 6.4 million people are currently infected with HIV (1) with a national budget of $1.2bn(2) per annum allocated. Research is based on official budget documents and interviews with government officials.

How it fits with the panel topic chosen:

This study focuses both on the policy decisions and implementation processes of performance measurement programs in health policy in a developing country using South Africa as a case study. This analysis looks closely at the financing mechanism and the feedback loops for monitoring both the financial and the programmatic performance

Results

This paper will show the impact of politics on budget setting and on the realized expenditure. One example is that budgets within many of the programme areas have been consistently underspent, while one specific programme area has constantly overspent its budget. This points to where high level political commitment lies with delivering certain services. From this analysis we see that allocation of funding may be less tied to performance and need but rather based on previous year's allocations and through political negotiations. Political negotiations have a greater impact on the performance targets set than the funding availability.

PAPER 3: MEASURING SHARE OF DRUG SALES IN REVENUES OF HEALTH FACILITIES AS A PERFORMANCE INDICATOR IN CHINA

Author : Chaojie Liu – Associate Professor, Department of Public Health, La trobe University, Australia - c.liu@latrobe.edu.au

ABSTRACT

China is the second largest pharmaceutical market in the world. Pharmaceutical sales account for 39% of China's total health expenditure. In the 1980s and 1990s, China introduced a pricing system that set low service prices but allowed hospitals to make 15% markup from drug sales. This led to over-prescriptions. Drug sales account for 45-70% of hospital revenues.

To bring down medical costs, the government developed a hospital performance measurement system that monitors the share of drug sales in hospital revenues. The government intends to bring it down to 30% in 2017.

Since 2009, China has implemented the Essential Medicines List (EML) policy for primary care with prices of drugs on the EML set by the government at zero mark-up. However, most medicines (>70%) are dispensed from hospitals with prices set after negotiations between the government and manufacturers. Income of hospital staff continues to depend on the revenues they bring to the hospitals with low level of governmental investments. Under the 15% mark-up policy, over-prescriptions are common especially for expensive drugs. But when medical workers are no longer able to obtain financial benefits from drug prescriptions, they quickly shift priorities to other revenue generating activities (eg. intravenous drips) to compensate for the loss.

The drug performance measurement has attracted enormous attention from consumers. The public believe that medical costs would come down if good compliance of the governmental policies is achieved. But when those policies failed to achieve their intended goals, consumers started to blame health providers. Trust in medical practitioners was eroded, exacerbating medical disputes.

Generic drug sales dominate the Chinese market (>80%). However, some medicines are still heavily dependent on overseas suppliers. Most insulin products, for example, are imported. We found that significant differences of insulin availability exist across pharmacy outlets. Over 90% of public hospitals had pre-mixed insulin products. By contrast, insulin availability in community health centers was very low, with 10% to 20% of community health centers having insulin products.

The government sent out a clear signal to the public for its intention of developing an affordable medical services system. But these policies provide perverse incentives to health providers, stimulating profit-seeking behaviors and demand-inducing activities. This, in turn, has damaged the image of health providers, fueled medical disputes, and diminished patient trust in medical workers. The drug policies have also inadvertently placed primary care facilities to a weaker position for providing appropriate care due to low availability of drugs.

Many factors have shaped the current situation in China. Some may argue that culturally Chinese consumers are more likely to accept drug therapy. Others may blame the lack of a stringent medical education system for the poor prescription performance of medical practitioners. But the lack of participation and endorsement of consumers and health providers in the development of the drug performance measurement system is perhaps the fundamental reason undermining the results of those measurements. In a highly fragmented bureaucratic system, a top-down approach is unlikely to deliver a good policy product without meaningful engagement of the public and health providers.

PAPER 4: FROM IDEAS TO POLICYMAKING: EXPLORING THE GLOBAL, CONTINENTAL AND NATIONAL PROCESSES LEADING TO ADOPTION OF PERFORMANCE-BASED FINANCING IN MALI

Author : Lara Gautier, PhD candidate, Department of Social and Preventive Medicine, Université de Montreal, Canada - lara.gautier@gmail.com

Second Author : Manuela De Allegri, Heidelberg University, Germany - manuela.de.allegri@urz.uni-heidelberg.de

Third Author : Ridde Valery, Université de Montreal, Canada - valery.ridde@umontreal.ca

ABSTRACT

Background: Over the past decade, several donors have promoted performance-based financing (PBF) in Africa, in view of increasing the quantity and quality of health services provision. In Mali, after participating in a pilot program, the Ministry of Health engaged in the scale-up of PBF. PBF policymaking in Mali is investigated through an analysis of processes occurring at the global, continental, and national levels. These notably include internal and external idea framing and constitution in PBF networks.

Method: Using public policy analysis and sociology theories, we adopt a mixed methods approach to collect and analyse data. We investigate PBF adoption through the analysis of ideational and network processes via semi-structured interviews with key stakeholders at the international, continental, and national levels (n=50). We further analyse network processes by investigating the constitution in networks with bibliometric analysis of scientific articles (n=115) and major grey literature (n=55), as well as social network analyses of authors (n=257) of 354 online forum threads. The latter are performed using the exponential random graph model and the multiple regression quadratic assignment procedure. Critical discourse analysis is used to analyse interview data. Using a triangulation approach, we confront quantitative results to qualitative interview findings.

Results: We identify a very active PBF policy community covering both global and continental levels. On top of economics theories, the members of this community mobilise popular international relations discourses, such as the ones of “good governance” and “local autonomy” to frame PBF. PBF is also anchored in the language of South-South learning, whereby “flagship countries” (i.e., Rwanda and Burundi) would become success stories from which other African countries could learn. In Mali, national promoters frame PBF as the logical continuation of pre-existing decentralisation policies.

In terms of networks, the PBF international and African community gravitates around a narrower PBF policy elite made up of experts who know each other from earlier versions of PBF in the African Great Lakes region. Financially supported by a specific trust fund and international organisations, the PBF community produces and disseminates multiple forms of PBF knowledge. A few Malian actors (i.e. former

government officials and former bilateral agency staff) showed strong commitment to PBF after participating to training and study tours organised by the PBF community. The latter also helps fuel the PBF policy through providing expertise and visibility to African PBF experts. A few of these African experts participate to the scale-up of the policy in Mali, thereby contributing to national policymaking.

Discussion: This is the first research focusing on the multifaceted and multi-level power of ideas and networks towards the diffusion of an innovation (PBF) in Africa, and in a particular setting (Mali). These findings imply that global health communities sharing a common policy framing, accessing material resources, and expanding their networks in successful countries may spark policy adoption faster in other countries.

PAPER 5: CONTRASTING APPROACHES TO PRIMARY CARE PERFORMANCE GOVERNANCE IN DENMARK AND NEW ZEALAND

Author : Tim Tenbensel, Head of Health System Department, University of Auckland, New Zealand - t.tenbensel@auckland.ac.nz

ABSTRACT

Primary care is a crucial component of health systems, and one which governments typically have a strong interest in being able to steer. Increasingly, this steering is taking place through 'performance governance' – the incorporation of performance measurement into institutionalised policy processes. Primary care presents many governance challenges because it is predominantly provided by independent practitioners in small organisations. In this article we compare two small, high-income countries with tax-funded health systems - Denmark and New Zealand which have adopted quite different instruments for performance governance. The Danish state governs primary care performance using 'soft hierarchy' based on accreditation processes but few strong sanctions, while New Zealand has relied more on a combination of explicit hierarchical targets and financial incentives. To explain this key difference, we use a conceptual framework that charts the connections between: (i) institutional contexts, including the organisational structure of primary care; (ii) governance processes (corporatist or pluralist); and (iii) governance problems such as access, equity, efficiency, quality, and population health. We argue that the specific nature of primary care institutions have a significant impact on regimes of performance governance. Our comparative framework has the potential to be applied across a wider range of countries.

PAPER 6: SELECTION OF PERFORMANCE MEASURES IN CONTEXT OF UNIVERSAL HEALTH COVERAGE

Author : Sundararaman Thiagarajan, Tata Institute of Social Sciences, Mumbai, India - sundar2016@gmail.com
Second Author : Alok Ranjan - alokranjancmc@gmail.com
Third Author : Priyanka Dixit - priyanka.dixit@tiss.edu

ABSTRACT

Background: Universal Health Coverage (UHC) has emerged as the major health policy discourse around the globe. Some of its proponents have even proclaimed it as third major transition after demographic and epidemiological transition, whereas others have called it as "old wine in new bottle". In one sense every country is moving on the path of UHC, some are near the starting line, some are mid-way and some have reached closer to goal. In this context measure of progress towards UHC becomes the central discourse- and how one measures can influence both its meaning and its directions. This study based on the recently released India's 71st Round National Sample Survey (NSS), 2014, measures progress in three contexts- as a comparative case study- its two most populous states, Uttar Pradesh (population: 199 million) and Maharashtra (population: 112 million) and for all India(population: 1221million).It discusses the implications of the choice of performance indicators with respect to the understanding of progress and the roadmaps.

Methodology: This National Sample Survey, 71st Round, 2014 was done for 65932 households (rural: 36480, urban: 29452) in India which included 3, 33,104 individuals). Also, 7921 and 5403 households were selected from Uttar Pradesh (UP) and Maharashtra, respectively. Insurance coverage, hospitalization rate, reimbursement, Out of pocket expenditure (OOPE), catastrophic health expenditure (CHE) at 10% (CHE-10) and 25% (CHE-25) and impoverishment were calculated for public and private healthcare providers. These indicators were also explored and evaluated through different equity dimensions of gender, caste, income quintile, and geographical location. Cross tabulation, multivariate logistic regression and propensity score matching were main analytical methods.

Results: Insurance did not have facilitating role in increasing hospitalization rates. Whereas chances of hospitalization consistently increased for richer category of population in all three contexts. Access to hospitalization was higher in higher income quintiles in both Uttar Pradesh – the states with one of the lowest human development index (HDI) in India and Maharashtra the state with one of the highest HDIs in India. Social group category played determining role in access to hospitalization in India and Maharashtra but not for Uttar Pradesh. Most persons who were insured did not get the benefit of cashless care and average OOPE between insured and non-insured offered some measure of protection in Uttar Pradesh, but not in Maharashtra. Propensity score matching showed government funded insurance schemes reduced CHE incidence for hospitalization at the 25% threshold by a meagre 6% in India. Out of pocket expenditure was significantly lower under public provisioning compare to private provisioning. Access to subsidized public services in contrast was more equitous and had a significant financial protection effect.

Conclusion: Measurement of health performance requires equity dimension integral to it. Government needs to be cautious while choosing insurance coverage as a performance measure in the discourse of UHC. When measuring financial protection both the type of provisioning and the type of financing needs to be studied together. This study fits in given panel topic.

PAPER 7: EXPLORING THE USE OF PAYMENT BY RESULTS IN HEALTH AND SOCIAL CARE IN THE UK

Author : Chris O'Leary, Senior Lecturer, Department of Sociology, Manchester Metropolitan University, UK - c.oleary@mmu.ac.uk

ABSTRACT

Over recent years, there has been increasing interest in 'Payment by Results' (PbR) (Pay for Success in the US) as a model for commissioning services in the public sector. A PbR contract links payment to the outcomes achieved, rather than the inputs, outputs or processes of a service (Cabinet Office 2011). By making some or all of payment to a service contingent on delivering agreed outcomes, PbR supposedly reduces 'micro-management' on the part of the commissioner, encourages innovation and transfers risk away from the branch of government commissioning the service towards the service provider because government will only pay if outcomes are achieved. From government's perspective payments for service are deferred. Given the need to reduce public sector spending, both the transference of risk and deferring payment for services are attractive propositions for government. To date, over £15 billion of services in the UK are subject to PbR contracts (National Audit Office 2015), in areas such as criminal justice, healthcare, and social care. Payment by Results and Social Impact Bonds can be considered as the logical conclusion of outcome-based performance management (OBPM) (Lowe and Wilson, 2015), as they are intended to ensure that financial rewards directly flow from the achievement of specified outcomes. OBPM is a general term used for using outcomes as a means of assessing performance (Lowe, 2013), and different forms of OBPM have emerged since the 1990s. OBPM is associated with New Public Management (NOM) (Hood 1991).

Currently there is very little written in the academic literature on Payment by Results, with the majority of publications to date are policy briefings produced by government departments and Think Tanks. Such publications should be treated with caution because their treatment of the (limited) evidence base is often partial and they tend to 'gloss over' theoretical and ideological debates that are not consistent with their agenda. Further, publications in their field to date tend to concentrate on either the UK or the US experience.

This paper seeks to examine the use of Payment by Results in health and social care in the UK. It will draw on a Rapid Evidence Review of the literature on PbR. Although formal evaluations of both PbR and are still limited some evaluation findings are starting to be published and some tentative conclusions on the potential for innovation are drawn from the REA. I will build on and develop the limited theoretical discussion and, in particular, explore two themes: one that PbR drive innovation in the delivery of health and social care; the other that PbR are simply an extension of government outsourcing that ultimately prioritises corporate profits over social goods. I will also consider the impact of these approaches on not-for-profit and smaller players in the market for social outcomes.

PAPER 8: THE POLITICS OF IMPLEMENTING A PERFORMANCE MEASUREMENT PROGRAM (PMAQ) AT THE FRONT LINE OF PRIMARY HEALTH CARE IN GOIANIA, BRAZIL: A QUALITATIVE POLITICAL ANALYSIS

Author : Fabiana C Saddi, PNPD-CAPES Research Fellow and Lecturer at Faculty of Social Science, Federal University of Goias (UFG), Brazil - fasaddi@usp.br

Second Author : Matthew Harris, Clinical Senior Lecturer in Public Health Medicine, Imperial College London, UK - m.harris@imperial.ac.uk

Third Author : Fernanda Parreira, PhD Researcher in Sociology, UFG, Brazil - fernandarparreira@gmail.com

Fourth Author : Raquel Pego, Visiting Lecturer, University of Brasilia, Brazil - rabra.pego@gmail.com

ABSTRACT

This paper´s objective is to understand how front line health workers in Goiania evaluate the Brazilian "National Program for Improving Access and Quality of Primary Care" (PMAQ) and from a political perspective.

PMAQ has the objective of inducing the increased access and improvement of primary health care quality, by means of mobilizing and holding responsible all agents of the process, including front line health workers. It has been implemented in every primary health care unity in the country and therefore generated new data and quantitative analyses in primary health care in Brazil. Comparatively, few implementation and qualitative analyses have been developed so far. Semi-structured questionnaires applied by us to front line health professionals (doctors, nurses, community health agents, and local managers) in Goiania have revealed that the program is mostly perceived as another top-down policy, in which all health workers are not involved (nurses and managers mainly), and in different ways consider (and not consider) it important to improve the quality of care, giving the political/rhetorical and organizational questions that arises in a complex implementation context.

In order to better explore and understand those new results related to PMAQ, we have interviewed 25 front line health workers so as to verify: 1) if and in what ways front line actors (and which of them) value the program, 2) which members of the health team effectively participated in the implementation of PMAQ and how it occurred and 3) if and how PMAQ modified the way in which the professionals assess and plan the work process.

The main contents/themes that came out from interviews were associated with political aspects highlighted by implementation theory and the more realistic-political approach of performance measurement studies. These literatures have stressed a list of factors which encourage or deter the implementation of PM (or are prone to foster unintended results). We have adapted their lists and associated them with themes revealed by front line health workers. The seven codes used in the analysis consist of: 1) The politics of adhesion, 2) Culture and organizational capacity, 3) Culture of assessment/monitoring, 4) Participation in the implementation, 5) Perceived impact of PMAQ, 6) Feedback and uses of results and 7) Ambiguous rhetoric.

Discussion/Results – The analyses of the politics of implementation at the front line can be considered as an strategy to generate new contextualized evidences about PMAQ. The improvement of PMAQ at the front line would mean the initiation (or revision) of a new organizational culture in the implementation of primary health care/PMAQ at the implementation ground, privileging a broader participation and involvement from front line health workers, with higher possibility of creating a (new) assessment culture at the front line and, consequently, guided by a new form of adhesion, involving more feedback and uses of PMAQ's results during both implementation and assessment, making thus possible to deconstruct rhetorics and ambiguities related to the program, and the construction of a new way of valuing PMAQ and the policy process related to it.

PAPER 9: HOW DO PHYSICIAN EXECUTIVES UNDERSTAND PERFORMANCE REVIEW AND ASSESSMENT? A LONGITUDINAL Q-METHOD ANALYSIS IN A PUBLIC HEALTH ORGANIZATION

Author : Alberto Asquer, Lecturer of Public Policy and Management, SOAS University of London, UK - aa144@soas.ac.uk

ABSTRACT

During last decades, various reforms informed by New Public Management doctrine have largely affected performance management and personnel policies by introducing, among other schemes, performance review and assessment (PRA) systems. PRA systems are generally expected to result in various positive effects at both the individual and organizational level, such as greater job commitment and satisfaction, employees' motivation, and performance. When coupled with performance-related pay (PRP) schemes, PRA systems are supposed to trigger efforts to attain individual or organizational objectives because of individuals' utilitarian expectation of rewards based on positive performance reviews.

The reception of PRA, however, is controversial, especially in public sector organizations where professionalism norms and political context conditions contribute shaping individual identity and conduct. In the health sector, physician executives (or doctor managers) feel that their decisions should be largely informed by deontological considerations primarily related to the ethical standards of the medical profession rather than to the attainment of individual or organizational objectives. In context conditions where political affiliation matters for recruitment and career prospects, physician executives may sense that their job perspectives are more dependent on party connections rather than demonstrated professional achievements. In such professional and political organisations, what do physician executives think about PRA? How do they reconcile their understanding of performance measurement and appraisal with respect to other deontological principles and pragmatic criteria that orient their behavior?

This study employs a longitudinal Q method to provides some evidence of the subjective viewpoints of physician executives about PRA systems. Q method enables to access the subjective views of physician executives about the role of PRA. Longitudinal Q method permits to detect how subjectivities vary over time. The analysis focuses on data collected among physician executives in a public sector healthcare company in Italy in 2013 and in 2016. The longitudinal Q method analysis (factor analysis and varimax rotation) showed that physician executives hold diverse and fragmented views on the role of PRA, which can be characterized as 'pragmatic', 'holistic', and 'disillusioned'. Interpretation of the results takes into account features of the 'political bargain' between the state and the medical profession in the public sector, which included the adoption of accountability and managerial control policies that, in part, eroded the traditional 'medical dominance' in the health sector. In part, physician executives try and reconcile their understanding of performance measurement and appraisal with deontological principles that orient their behavior. In part, they may even regard the PRA system consistent with the canons of conduct of the medical profession, especially in the extent to which they consider it aligned with the attainment of health objectives of organizational units. In part, however, they view the PRA system as bearing little if any effects on behavior and performance, although they also consider the PRA system functional to the production of legitimacy for the health organization in the eyes of external stakeholders and political supervising agencies.