

FROM HIERARCHIES TO NETWORKS: CHANGES IN ORGANISATION OF PUBLIC SERVICE DELIVERY

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ABSTRACT

Government services slowly enter new and promising era. The traditional way of organising public sector service delivery in western democracies is hierarchical. Hierarchical organisation means functional specialisation. Top layers of the hierarchy specify and specialise different parts of the hierarchy in the bottom to provide rather specific functions – services. Service provision is then fragmented. Citizen in need of long-term help often ends up using many services with low cooperation between them. These conditions lead to high costs and low quality. We currently can identify in Europe promising cases of institutions which are organised as network organisations and sometimes even changed their structures from hierarchal type with great success. In this paper, we discuss what drives hierarchical organisation ineffectiveness when supporting people suffering with complex problems and what are some of the crucial conditions to organise successful network based integrated services. There are four principles discussed that are common to successful network organisations which are very different from the principles of hierarchically organised institutions – holistic service provision, flat organisation structure, high trust and capability measurement. These principles are shown on three cases - Jeugdbescherming Regio Amsterdam (child protection, Netherlands), Karolinska University Hospital (Sweden) and Buurtzorg (health and social services, Netherlands).

Keywords: hierarchy, network, integrated services, organisational change

Introduction

The idea of public sector services integration has attracted the attention of many policy-makers around the globe in recent years. The main reasons for this are dissatisfaction with the current business-as-usual approach and the perceived lack of effectiveness and efficiency of many public services. To fully understand the growing calls for integrated services, we first have to understand the main problems affecting the management of public services. Beyond this, to see what kind of integration of services we should seek, we must explore the key requirements of better service delivery.

There has been a strong focus on performance in the public sector at least since the 1950s [Dooren, W. V., Bouckaert, G., & Halligen, J., 2015]. We have seen numerous reforms which have aimed to ensure that public services are fit for purpose and efficient. Despite these reforms, our public services often still struggle to help people out of poverty, to reduce youth unemployment, or to prepare for the demands of aging population [OECD, 2016]. These social problems are often called “wicked” problems because they are persistent and not at all easy to solve. Why?

First of all, the essence of these “wicked” problems makes them hard to address directly. They are typically caused by multiple and complex causes, which means: (a) that the situation of citizens in need of help results from the presence of multiple causes simultaneously; and (b) that these causes feed each other [OECD, 2016]. Also, some of the causes of the problematic situation

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cannot even be removed, but only mitigated (this is the case for example with some chronic health issues).

What does this mean for public services? Goals or final states are highly ambiguous and cannot be specified easily. This means that it is hard to pre-specify where the service should help the client get without even seeing the client, because this might differ from one person to another. Furthermore, there is high causal uncertainty, meaning it is not clear beforehand whether an intervention will work or how [Moynihan, D. P., 2011] Finally, since multiple causes vary significantly in their character, various kinds of expertise are needed at the same time [Van Dooren, W., & Willems, T. (2016)].

Imagine **Ruth**, who has 6 children with three husbands, was a victim of domestic violence, struggled financially, lived in a sub-standard home, had health problems, and was socially isolated. She had 124 interactions with different agencies between 1996 and 2012. After being part of the Participle pilot project [Cottam, H., & James, R. ,2013], her situation is now stable [Locality, 2014].

Public organisations in the western world do not always have the optimum structure to meet these complex needs. Organisational units are usually functionally specialised: they have high expertise in very specific aspects of human well-being, but low interconnectedness with other units. Work is organised in hierarchical structure. Also, service provision is very often pre-specified by rules, procedures, ICT and performance management, which leaves very limited space to customise services to meet user needs. When facing multiple-cause problems, the combination of these two aspects leads to high system inefficiencies and low service effectiveness. Since simply putting different services in one building to create 'one-stop shops' does not address these two problems, possible improvements are very limited.

However a very promising body of literature and practical experiences is starting to grow which shows us how to substantially improve services and service collaboration. Work is in this case organised in flat network structure. Not all problems can be resolved as such, but the quality of life of people who are suffering can always be improved.

Hierarchical organisations: Product-dominant logic behind public service delivery

The design of public services remains largely influenced by organisational management principles introduced by Taylor, Weber and others in the early 20th century. These were very successful in the production sector. Derived from private sector performance systems, which emphasise efficiency, they were further refined in the 1990s, with the introduction of New Public Management [Hood, C., 1991] Output indicators, targets, performance contracts etc. all aim to ensure the efficient delivery of pre-agreed outputs [Dooren, Bouckaert & Halligen, 2015].

This product-dominant approach is based on an assumption that there are economies of scale. The production of complex outputs for customers is divided into small manageable parts. Each organisational unit is then responsible for producing a high volume of these small parts to create the final product which fits together. This is solved by pre-specifying parameters for the production process and for the output. To improve performance, production of these small units is measured and pushed to higher efficiency by performance measurement.

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The result is a hierarchical type of organisation, where the lower the organisational unit, the more specific the task it is fulfilling. Only the higher levels of the organisation have an overview over production, and their responsibility is to manage the small units so that the final product meets the customers' needs [Meuleman, L., 2008]. The underlying idea is to have a complex organisation that does simple predefined tasks [Wauters, B., 2017].

When service provision is organised in this manner, the citizen is perceived as a consumer of the public services that are produced. Consequently, the goal is then to plan and project the production of services that best fits the demand of citizens [Osborne, S. P., Randor, Z., & Nasi, G., 2012].

Flaws in a product-dominant logic when challenged by 'wicked' problems

In the western world, public services and their provision are usually organised according to a product-dominant logic. Expertise is concentrated in small narrowly-focused units. These units also have most aspects of service provision – volume, duration, eligibility etc. – pre-specified through rules, procedures, ICT and performance management. The structure of such organisations is hierarchical.

The result is that the public sector is full of 'silos' which need to spend a lot of time gathering information and feeding it into the ICT system or reporting it to higher levels of hierarchy. This information mainly concerns how the units comply with rules, procedures and performance metrics – or even on how the service user complies with what is expected of her/him (for example in unemployment measures).

The relationship with the customer is transactional. First, the citizen's eligibility for the service is checked, then the pre-specified service is provided. As regards wicked problems, several issues stem from this logic. These problems are also tightly interconnected. To be able to provide a successful integrated service, they all need to be challenged.

First, the capacity to interact with different units is limited. This is mainly because the front-office staff do not see the big picture. Narrowly specialised units are trained to detect and react to a precisely specified demand. So when a citizen contacts them with her/his need, they are trained to check eligibility and then support him/her with their pre-defined service, not to specify what other services and experts are needed in that concrete case.

Second, the pre-specification of services further limits the space to react to different causes of the problem in a way that is specific to the citizen. For example, an unemployed older man is looking for a job and is sent on a requalification course, but he has severe psychological problems with depression, self-esteem and motivation. Without firstly helping him with his psychological state, the effect of training would be very limited. But in pre-specified service provision driven by product-dominant logic, front-office staff mostly check the citizen's eligibility for the service and then offer it. There is usually also a risk connected with non-compliance with regulation and metrics which further limits the scope to customise the service.

Third, since the system is transactional, there is no expectation that a relationship will be created between the public organisation and the citizen. Without trust and relatedness, it is very hard to understand all the complex causes of wicked social problems. Problem detection might end in recognising only the consequences of a problem, without knowing its real causes. Citizens with health or social issues are forced to go from door to door, from service to service, where interactions are very formalised and his/her situation is understood in bureaucratic terms. This limits the citizen's motivation to cooperate, to openly admit what the problem is, or even to use

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the service. He/she might not even have space to truly specify what is needed to improve their situation.

Forth, for manufacturing, planning of production and its measurement is typical. Performance management movement brought this to the public sector. Output measurement with targets is quite usual also in the area of social services. Output or rather simple outcome quantity measurement enables organisation to push performance to higher efficiency and at the same time control performance of low levels of hierarchy. However, social needs are usually quite complex and it is very hard to measure it quantitatively and objectively with taking subjective view and needs of each client into account.

From the higher levels of the hierarchy, things might all seem fine. There are highly efficient units producing high volumes of services, which look successful according to predefined metrics. From the citizen's perspective, we get a totally different picture. For example, an analysis of services in Swindon (UK) showed that 24 departments were offering 73 services to families in crisis. These services are unable to understand family problems holistically and from the user perspective [Cottam, H., & James, R., 2013].

This absence of a holistic approach places an artificial demand on public organisations. Since the services mainly check eligibility and offer narrow expertise at one time only, the core situation often remains unresolved. Families (or other troubled citizens) then remain in their problem situation – and so they remain eligible for the current services. In this cycle, the cost of public sector service provision rises, even if the unit costs stay low. For example, one case study carried out by Vanguard in the UK studied the health needs of 21 citizens: they placed 79 demands on the acute health system, 75 demands on general practitioners, 55 demands on district nurses and 30 demands on adult social care [Cottam, H., & James, R., 2013].

To sum up, a product-dominant logic behind services which aim to solve wicked social problems may lead to internally efficient units (agencies), which are at the same time externally ineffective – thus creating public service system-wide inefficiencies.

Network organisations:

A service-dominant perspective and integrated services as an alternative

There is a growing awareness of a different way of working, rooted in an alternative logic and based on different assumptions about what works. These assumptions are taken from service management theory [Osborne, S. P., & Strokosch, K., 2013], design thinking [IDEO], systems thinking [Seddon, 2008] and developments of the New Public Governance framework [Torfing, J., & Triantafillou, P., (2013)].

To successfully organise services addressing complex problems, the difference between products and services should be understood. There are at least three significant differences [Osborne, S. P., & Strokosch, K., 2013].

First, services are intangible and their quality is not only the result of their parameters. The expectations and experience of service users are also important, and together they inform perceived quality.

Second, in the production environment, production and consumption are separated, but services are produced and consumed simultaneously. The process of service provision is thus crucial in creating a high-quality result.

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Third, in the case of a product, the user can be perceived as a consumer. He/she customises a product to her/his needs by selecting the right product, and after choosing it the product is consumed and the need is satisfied. In the case of services, these are always co-produced by the user, not only consumed. This is because quality is formed not only by service user expectation and experience, but also by the service user input.

These factors require a much closer focus on what happens during service provision and on how the user perceives the service, rather than on compliance with pre-specified rules. So how should the process of providing services to tackle wicked social problems be structured? The service-dominant perspective leads us to create integrated services that have wide expertise and enough decision autonomy to find the right solution for each specific citizen, including by networking with others outside the unit. At the same time, providers need to focus clearly on building relationship with citizens. Thirdly, since there is high causal uncertainty it is not clear whether service design will lead to success, or if customer-centred measurement is a better choice than output-focused measurement. In result, work is organised in flat network based manner. We now discuss each aspect separately.

Since complex social problems have multiple causes (psychological problems, health problems, low competencies, bad housing conditions, drug abuse, etc.), services need to be able to absorb and react to a highly variable demand. Front-office employees need to have a wide expertise in providing different services at the same time (give medication, help with psychological issues, help to find adequate training, etc.). If it is not possible to access such a wide front-line expertise, then different services need to be integrated around users [Wauters, 2017]. This might be done by creating a service with, at its centre, a professional trained to build relationships with troubled citizens and to understand their needs. This professional then sits a specific set of experts round a table with the troubled citizen to plan together how to tackle the situation holistically.

This leads us to the second precondition of success. There must be enough decision-making autonomy around the design of the user-specific path of service provision. Pre-specification should thus be very limited. The organisation needs to trust its experts to do the job as best they can. Experts from different fields that are close to the citizen are then able to choose the strategy which helps best.

Service provision needs to be based on trust. The front-line worker who is closest to the customer ensures that the citizen trusts each member of the team. This is supported by giving the user significant decision autonomy to choose which route to take, using experts as guides. The experts are also there to help the user to stand on his/her own feet, preventing dependency and reducing future demands on public services.

Finally, when dealing with wicked social problems, customer-centred measurement is appropriate. Since there is high degree of uncertainty, if the troubled service user makes it to the point where he/she can stand on his/her own feet, it makes much more sense to measure the capacity of service provision to get her/him to that spot, rather than whether something was provided as planned by rules, procedures, ICT and performance measurement. This can be done by analysing the citizen's situation into a series of phases, and then checking how and why they are moving forward from one phase to another, without putting any rigid timing on this. Some people will always need more time than others because their context and characteristics differ. If, however, someone clearly is getting stuck for too long and the reasons go beyond anything the front office can tackle, it can pull in help from supporting experts to find a different strategy or escalate the issue (if it is of a general nature) to management. This type of measurement thus

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serves as a learning instrument about what works and what does not, and when more expertise or higher-level action is needed.

Given the extent and complexity of client needs, a 100% public service success rate is unachievable. However, a more client-centred approach involving an integrated service response can achieve system-wide cost savings and better outcomes. Recognising clients' expertise in diagnosing their own support needs and progression can also be hugely empowering. Even if they are not yet on their feet completely, they have a stronger sense of control over improving the quality of their lives. This, surely, is a key step towards a rebalanced and improved relationship between citizens and public services.

Tab 1.: Comparing product dominant and service dominant logic while serving people with complex needs.

	Product dominant logic	Service dominant logic
System of management	Fragmented, each organisation is accountable to its own hierarchy, there is low common service quality focus of the serving organisations.	Holistic, there is central coordinating organisation that guarantee service quality for whole serving network.
Front office autonomy	Low, service design and eligibility to be served is highly pre-specified from top of the serving organisations.	High, services and needed expertise for each client is set at front office or just above it. Pre-specification leaves room for high customization.
Trust	There is low trust both in between low levels of hierarchy and top of the hierarchy and between clients and serving organisations.	High trust both inside and between serving organisations and between them and clients are crucial.
Measurement	Output and limited outcome measurement. Focus is on objective data. Purpose of the measurement is to control and support efficiency. Measurement mainly answer question "are we implementing as we planned?"	Process measurement. Purpose of measurement is to learn to be more effective. Can be based on front office expert estimate (some subjectivity is acceptable). Measurement mainly answers question "are we helping?"

Table 1.: Comparing product dominant and service dominant logic while serving people with complex needs.

Seeing theory in practice

These theories are being applied in various cases around western Europe in both the public and non-profit sectors. In the United Kingdom, there was quite a successful pilot project (Participle) aimed at families at risk [Cottam, H., & James, R., 2013], while in the Netherlands there are

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striking examples of very successful futuristic services concerned with child safety [Wauters, B., & Dinkgreve, M., 2016] and community home care.

Another very interesting case is now being developed in Stockholm (Sweden), where the biggest hospital is currently going through reorganisation into a new operating model of integrated care [Karolinska Universitetssjukhuset, 2016]. These cases really show us ways of doing more with less by preventing artificial demand, and by acting on issues before they become expensive to act on, by focusing on what is really important for the clients.

We discuss three cases below. Child Protection in Greater Amsterdam is especially interesting because of its transformation from a product dominant to service dominant operating model. The Buurtzorg case then shows us how to create an organisation with wide expertise on the front line with a highly customisable approach to its clients. Finally, the Karolinska hospital is a promising case of how to integrate different specialists around clients' needs.

Child Protection in Greater Amsterdam

This text is based on a two-day study visit by the ESF Public Administration and Governance Thematic Network and the case study paper prepared for it [Wauters, B., & Dinkgreve, M., 2016].

Background

Jeugdbescherming Regio Amsterdam (aka Child Protect) is a public agency covering the greater Amsterdam region where it looks after around 10,000 children at risk with about 600 staff. Its goal is to support families so as to create a safe environment for children up to 18 years old. Children at risk are referred to the agency by teachers, police officers, doctors or other professionals that perceive a risk that child may be abused or neglected. Parents can choose to accept support from the agency voluntarily, or support can be imposed through a court decision. The agency also supports children who have been sentenced for an offence and are now on parole. In each case, there is scope to cooperate with a range of welfare services such as foster homes, parental support groups and mental health services.

Crisis point

In 2008 Jeugdbescherming was placed under heightened supervision by the government bodies responsible for oversight, because it was perceived as being unable to fulfil its core mission or control its own organisation and finances. At this point a new CEO conducted a thorough analysis of the situation.

This concluded that the core work was functionally divided among three groups of people – social workers who worked with parents on voluntary basis and who referred children to other services; guardians who had legal responsibility for children under state care, based on court orders; and parole officers who worked with (convicted) juvenile offenders. As a result, some families were confronted with more than one caseworker who each time had to start from scratch getting to know the family, building trust and gathering information. Some families had been in the system for 8 to 10 years and had been serviced by 20-25 people from Jeugdbescherming as well as other services.

A lot of a time was spent on complying with (real or imagined) prescribed protocols and targets. Extensive case reports often grew to more than 100 pages. Arbitrary targets were set, e.g. see a family in five days, or have a plan signed in six weeks. Service provision looked mostly the same

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for each family and did not consider the specific needs of parents caused for example by a mental disability. Employees perceived compliance with protocols and targets as providing a safe environment – getting it right meant providing the sense of doing a good job even if the service was not helping some of the families at all.

The system of work was rather bureaucratic. Workers held frequent meetings with each other to talk about the families, but the time they actually spent with families was very short. Instead of that they were sending a lot of letters that were hardly read and understood (because of limited capacities to understand the letters or simply because of fear of opening them). Meetings were often held with families at the organisation's offices for limited amounts of time.

Team managers mainly focused on the size of the case load and on the capacity of workers to take on new cases. At one time, social worker would be responsible for around 60 children, a guardian for 18 children and a parole office for 22 children. With the targets in place, the organisation focused mainly on quantity, and no information on quality was available.

The result of this design was to focus capacities on children with the highest risk, but the situation of the lower-risk children deteriorated over time and generated demand for more specialised services later.

The new way of working

Jeugdbescherming now works in a completely different way. Organisational silos were abolished and replaced by teams that can take on any kind of case. In each team there are 6-8 case workers supported by a team manager and a senior case manager who acts as a supervisor and has thus a lower caseload to manage herself/himself. Also, each team is supported by a specialist in behaviour and child development (a psychologist). If there is a need, teams can pull in expertise from other specialists at headquarters.

Each family has only one worker, who takes care of them and helps them to create a plan to get out of their situation. Teams and case workers have high autonomy to decide how to work best with each family. Case workers now spend most of their time with the families, where they analyse the situation, build a trusting relationship with the families and coordinate networks around them. Also they are the main contact point for the families, so the families can always call them to get help.

Case workers always try to bring a 'whole system' approach into the room with their families. So for example when the plan for a family is being developed, all family members including the child, case worker, and other relevant people are present. These could be grandparents, local teachers, police, or specialists from mental care or healthcare services. There are cases, for example, where one parent is in jail, and the case workers host the meetings in the jail so that they are sure that everybody who is important for the family to change their behaviour is there.

Experience with the previous design of work showed that simply telling families what to do did not work. Impersonal communication via letters, e-mails or phone calls is highly ineffective. An absolutely crucial part of the case worker's job is to get families and networks around them to reach a joint judgement of what is not going well and how to improve it. Families must be willing to accept help, and help must lead to a sustainable change in behaviour.

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The monitoring system was changed as well. It no longer focuses on delivering quantity (plan in 6 weeks, visit in 4 days etc.). Instead, measurement is focused on assessing whether the service is helping the family to get back on its feet so that it no longer needs Child Protection's services. The work with families is structured in three phases: (1) engage and motivate; (2) support and monitor; (3) generalise. The time each family spends in each phase differs very significantly and there are no specific targets that must be met. But when family is stuck in any phase for a long time, this triggers discussions aimed at finding the best solution in that case. Some other aspects are also measured. In the centre is child safety monitoring. On each family visit, case workers rate the safety of a child on a scale from 1 to 10. A score of 5 is insufficient, while 6 is just ok. In this way case workers can track how the situation is developing and if the service is helping or not.

When the situation is rated as 10, the family is ready to continue on its own, Each team has four hours of meetings each week, where they discuss their families, taking the measurement as the starting point. Usually between 8 and 20 cases are covered: team members can learn from each other what worked in various situations, and can ask for advice when they are stuck with a particular family. For each case four questions are asked: (1) Who is the child? (rather than focusing on the parents or family issues); (2) How did it get to be that way? (3) What does the child need? (4) What is the next step?

The new service design brought about more changes than expected in the efficiency and effectiveness of the service. The number of cases where legal instruments had to be used to compel parents to cooperate was reduced by 60%, and the number of children forcibly removed from families decreased by 50%. Youth parole decreased by 45%, but this was mainly due to a policy change by the prosecutors. Legal guardianship (by a case worker) decreased by 16% (while it rose nationally by 3%). The total budget was reduced from €53 million to €34 million, and a further €11 million (at least) was saved in the child protection system as a whole.

Buurtzorg

In 2006 a former community nurse, Jos de Blok, a manager and director of different care organisations, developed an idea to reuse old community care principles while supporting them with new management ideas and ICT possibilities. He started with one team of nurses in 2007. General practitioners supported the idea and within a year, 12 teams were operating. The good results quickly attracted attention [Buurtzorg Nederland, 2011].

Buurtzorg ('Neighbourhood Care') is now a unique district nursing system which in 2015 served around 70,000 patients. Patients are cared for by 6,500 nurses working in 580 teams. Buurtzorg delivers care for patients who are terminally ill, have chronic diseases, or have cancer, dementia or other illnesses. Its operating model is based on self-managing teams of a maximum of 12 professionals (mostly nurses, supplemented with allied health professionals). Each team operates in a specific geographical area in which it provides care to 40 to 60 patients [RCN Policy and International Department, 2015].

Since the nurses operate in self-managing teams, there is high decision autonomy and with it also responsibility for patient care. Nurses assess, plan and coordinate patient care. They can handle a lot of tasks by themselves, but they also cooperate with other formal care institutions in the area and coordinate care for their patients. Within the team they discuss progress or problems with patients.

The nurses are highly trained so that they can support patients with a wide array of services. This is as opposed to the more usual approach where patients with complex diseases are visited each

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week by various specialists who only carry out specific tasks and who are under time pressure because they need to travel from patient to patient each day. Nurses at Buurtzorg can handle activities from low-level care to highly technical tasks such as infusion therapy and palliative morphine therapy. To build a trusting relationship and to understand patients' needs better, nurses also help with personal needs if this is required [Buurtzorg Nederland, 2011].

There are expert groups at Buurtzorg composed of nurses from local teams who care for patients with various specific needs. These expert groups develop standards for Buurtzorg as whole. In this way local teams are interconnected, communicating via the Buurtzorg web portal. The back office is very small with around 47 people supporting 6,500 nurses. Buurtzorg is thus a real network, not a hierarchy.

Buurtzorg nurses do more than coordinate formal services for their patients; they also map informal networks and try to involve these informal carers in the patient's treatment plan. This is supported by the historically good community position of nurses in the Netherlands. As a result, there is a strong focus on building relationships not only with clients but also between the clients and their communities.

The patient care outcomes are tracked by rather a robust monitoring system called The Omaha System.¹ This enables Buurtzorg to gather evidence and improve its service delivery.

Patients perceive Buurtzorg as a high-quality service: in a 2009 survey it scored the highest satisfaction rate in the country. Compared to other home care organisations, Buurtzorg can achieve the same outcomes at a 40% lower cost. In addition the quality of Buurtzorg services leads to a 50% reduction in hours of care needed, owing to the way it promotes health, self-care and independence [AARP, 2013].

Karolinska University Hospital

The third case is a little bit different from the previous ones for two reasons. First, the scale of demand that is met by the organisation presented is much higher than in the previous cases. Karolinska University Hospital is the largest hospital in Sweden, providing universal healthcare. Second, the redesign of its operational model is not yet finished, although it is scheduled for completion in late 2017. We draw attention to this case here because the hospital might really be leading the way in designing health services and research together in the 21st century. Its approach is based on value-based health care and is heavily inspired by the work of Porter [Porter, M., 2008] and researchers from Karolinska Institutet [Elf, M., Flink, M., Nilsson, M., Tistad, M., von Koch, L., & Ytterberg, C., 2017].

As was indicated, Karolinska University Hospital works closely with Karolinska Institutet which is a research centre and medical university (ranked in the top 3 in Europe and the top 10 in the world). The hospital's 16,000 employees are supported by 2,700 researchers from the institute, who together serve 1.5 million patients each year. With major investments in new facilities, they are also trying to switch to a new operating model, which would ensure that care is provided holistically from the patient's perspective. The hospital's main focus is to constantly improve its capacity to provide value for its patients, while cutting costs and ensuring that research is closely interconnected with the healthcare provided in the hospital [Uggla, A. R., 2016].

The previous organisation of the hospital was quite typical. It was structured into different clinics based on functional lines. Each clinic had its own budget and its own health outcome

¹ <http://www.omahasystem.org>

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measurements, and the organisational structure did not support coordination between them. Instead each part of the organisation looked after its own budget and plans. Thus, the separation of different functions into specific departments hindered the customisation and integration of care, resulting in inconsistent quality of care. The decision was made to change the hospital structure to integrate different healthcare functions and improve health outcomes [Uggla, A. R., 2016].

The hospital structure is now radically different. It is no longer organised into clinics performing specific functions. Instead, it is organised around specific patient pathways. Patients are categorised based according to their health issues into 400 groups (for example breast cancer, child diabetes, etc.). These are then aggregated, based on the similarity of care needed, into patient flows, which are further aggregated into 7 health themes (cancer, neurology, etc.). Thus, the approach is bottom-up.

Patient pathways

The most important level of the Karolinska University Hospital system is the patient pathway for a specific patient group. At that level, specific functions are integrated and decisions about processes, measurements, costs etc. are made. Each pathway is managed by a patient flow manager who has hiring and firing power for the specific competences that are needed for that specific patient group. He/she can hire any competence that makes sense.

At the patient pathway level, a patient flow manager governs an interdisciplinary management team. This is composed of different medical functional representatives, patient representatives, researcher/teachers, controllers and others so that every competence needed for that specific patient group is present. Based on meetings of this team, decisions about health care processes are made, health outcome measurements are selected and even demand for specific research is formulated. Meetings are supported by high-quality data so that decisions are informed.

This does not mean that specific functions have ceased to exist in Karolinska University Hospital. They still develop their competencies together, supported by research, but the hospital is no longer organised around them.

A high level of trust is present. It is needed so that the multidisciplinary boards for each patient pathway can cooperate, share different perspectives and find agreement on how to deliver more value to patients. Patients are involved in decisions about their treatment, in order to involve them in the care process and ensure that a trusting relationship between them and the hospital is maintained.

The system for measuring health outcomes has also changed. It used to be specific to each function and focused on the outcomes of single interventions. Now, the measurement is developed specifically for each patient pathway to monitor the health outcomes of the whole healthcare process. Using this measurement, the hospital plans to cut costs by comparing the health outcomes of patients going through a pathway with those of all interventions undergone by patients in the process.

Since this new operating model will not be fully implemented in 2017, no data are as yet available regarding the results of the change. However, Karolinska University Hospital is an inspirational case to watch and learn from.

Conclusions

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All three cases are examples of services designed using service user centred logic. To conclude, we examine where theory and practice meet each other in the three cases.

Citizens who are struggling with complex social or health issues need to tackle numerous problems at the same time. These often require different kinds of expertise. Public organisations in the western world are often organised into functional hierarchies, and at the bottom of the organisation we find very narrowly functionally specialised units with high expertise but little capability to see the bigger picture. However complex problems require seeing the bigger picture – otherwise they are only likely to be solved purely by chance.

To overcome this problem, expertise needs to be integrated close enough to a problem so that the solution to numerous causes can be identified at the same time. This can be done by creating units that have a wider expertise and thus can address more problems at the same time. If this is not possible, a network of experts is needed, which can collectively help the troubled citizen. Services for tackling ‘wicked’ social problems are thus organised from the service user’s point of view, not functionally.

Both Jeugdbescherming and Buurtzorg have designed their services to have front-office workers with high and wide expertise to help their clients with all kinds of issues. They must be good at analysing the needs of their clients, and they must be psychologically strong and able to understand the client situation truly holistically. When it is not possible for one front-office worker to have a wide enough range of expertise, services from all three cases integrate different functions into a network around the client.

Jeugdbescherming and Buurtzorg work with formal and informal actors around their clients and set up individual plans to serve them. In Karolinska University Hospital care is integrated in networks at the level of patient pathways which are structured around 400 categories of health issues with different needs.

Since the need to see the big picture even from the bottom of the organisation is met in this manner, it is important to leave significant decision making autonomy as close to the service user as possible. High decision autonomy at ground level encourages staff to find the most effective integrated support solution possible.

All three cases presented design their services very similarly. There is always a front office which helps users to navigate the best way through the service delivery process. Space for decisions on the front line is conditioned mainly by the network which is just above the front office and is composed of colleagues and other professionals. In Buurtzorg it is the team of nurses with other helping experts, in Jeugdbescherming it is again the team of front-office workers with senior members, team leaders, psychologists and, if needed, other experts. In the case of Karolinska Hospital it is a board specific to each patient pathway together with a network of experts once again.

The higher layers of these organisations serve more as a support to these networks. They help them by collecting the right data, by educating them, and by solving true systemic issues that cannot be solved by the front office or the team just above it.

The third important principle – trust and relationship building, both among members of a network of service providers and between service providers and the service user – is again an integral part of the work of each of the organisations. All three of them involve service users in decision-making processes about treatment or service provision. Especially in the case of troubled families in Amsterdam, without building relationships with them and without the intention to come to a

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common understanding of the problem, the service was highly ineffective. In all three cases, trust helps people to better understand what the real purpose of the service is, and what the causes of citizens' problems are.

And finally, all discussed organisations measure value of the processes serving the clients. It enables them to constantly learn if they are currently helping the clients or change in service provision is needed to bring outcomes.

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