

Daily practices of operational healthcare managers

Dealing with tensions between different values

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This article gives an empirical analysis of normative questions that come up in the daily practices of operational healthcare managers in the Netherlands. Since the recent introduction of client based financing in the care sector, managers are expected to provide more client-centered and affordable care. In practice, managers experience ambiguity and tensions in the operationalization of these different values. By looking into local management practices, light is shed on the way managers actually deal with these tensions. On the basis of qualitative interviews with healthcare managers, four modes of dealing with tensions between different values are established: balancing values individually and collectively, prioritizing one value over the other, establishing compromises between values and making healthcare workers responsible for balancing different values. Our findings show that managers increasingly feel pressure to more tightly manage their financial budget on location level. As a consequence, managers try to find solutions to keep care affordable, which they often feel ambivalent about. Nevertheless, managers also create flexibility in the new financing system by accomplishing compromises between values and reframing responsibilities for care. The authors conclude that it is necessary to raise more awareness for the specific moral problems that operational healthcare managers experience when managing tensions between values.

[operational healthcare managers, tensions between values, empirical ethics, client-based financing, care sector, the Netherlands]

Healthcare managers increasingly play a role in making decisions about the quality and distribution of care (Wall 1989; Dracapoulou 1998; Young 2003; Currie 2006; Van Hout 2006; Darr 2007; Stoopendaal 2008; Putters 2009). As a consequence, daily normative decisions about which types of care should be provided and to whom, are no longer primarily the terrain of healthcare professionals such as doctors, nurses and other care givers. Healthcare managers therefore have to find answers how to legitimately handle normative questions concerning a variety of issues, ranging from the allocation of scarce resources, cost containment and personnel management to

overseeing quality and accountability initiatives and the protection of patients' rights (Wall 1989; Dracopoulou 1998; Weber 2000; Gallagher 2002; Van Dartel et al. 2002; Grit & Meurs 2005; Darr 2007).

Given these shifting responsibilities in healthcare, several authors plead for the development of universal ethical principles that healthcare managers should apply in their dealings with clients, care givers, society and other parties. It is argued that just like healthcare professionals, managers should have their own professional ethics to determine which values are important and how to balance different values (Wall 1989; Dracopoulou 1998; Weber 2000; Darr 2007).

Interestingly so, this appeal for an ethical framework for managers runs counter to the 'empirical turn' that has recently been taking place in medical ethics. Rather than considering care as a 'moral fill in' of universal principles and values, several authors argue that it makes more sense to consider the ethic of care as a practice, in which the provision of good care is not so much determined by ethical principles but is more a matter of *doing*, attentive experimentation and tinkering (Tronto 1994: 148; Mol et al. 2010). This shift away from applied ethics (the application of universal rules) towards everyday normative issues, has led to a recent appeal for more empirical studies of every day practices in healthcare (Willems & Pols 2010). Willems and Pols argue that by looking at local practices, a better insight is gained into how care givers and other actors conceptualize and deal with different values, ranging from efficiency and effectiveness to client-centeredness and justice. These different values can be seen as 'varieties of goodness' which sometimes clash and therefore require a lot of work to make them coexist in practice (Von Wright 1972; Mol et al. 2010; Willems & Pols 2010).

In this article we would like to contribute to the appeal for empirical studies of every day normative questions by looking at the various ways healthcare managers deal with tensions between different values in their daily practice. We will specifically focus on the recent introduction of client-linked budgets in the care sector. The so called 'weighted packages' (in Dutch: *zorgzwaartepakketten*) are seen by the Dutch Ministry of Healthcare as a policy instrument that enables the attainment of multiple values. This new system of output finance is expected to give healthcare providers the incentives to provide affordable care and at the same accomplish more client-centered care. Policy expectations concerning the attainment of (public) values however often play out differently in practice. The operationalization of values is not a technical activity of implementation, but a process that alters the form and shape of those values (Weick 1995; Stone 2002; Frederickson & Smith 2003; Pollitt & Bouckaert 2004; Zuiderent-Jerak et al. 2010; Bozeman 2007).

Healthcare managers play an important role operationalizing values in their work with client-linked budgets. Especially operational managers at location or unit level, who directly deal with healthcare workers, clients and client-linked budgets, have to weigh affordability and client-centeredness at the same time. They carry the dual responsibility for finances as well as the quality of care (Stoopendaal 2008). This dual responsibility, combined with the fact that most managers have a professional background as healthcare worker, makes them an interesting layer of management to

research the enactment of different, possibly competing values (Damhuis et al. 2003; Young 2003; Currie 2006; Van Hout 2006; Elshout 2006; Stoopendaal 2008; Putters 2009; DeChurch et al. 2010). Furthermore, within the literature there appears to be a disagreement whether this layer of management feels comfortable or compromised managing different values in the context of a more businesslike approach to healthcare (Gallagher 2002; Bolton 2003; Young 2003; Pappas et al. 2004; Currie 2006; De Vries & Van Tuijl 2006; Van Hout 2006; Elshout 2006; Stoopendaal 2008; Actiz 2009; Cathcart et al. 2010; Mitton et al. 2011). By looking at the way healthcare managers deal with tensions between values in the context of client-linked budgets, further insights will be gained into this discussion.

On the basis of qualitative interviews with operational healthcare managers at location or unit level we would like to answer the following research question:

How do operational healthcare managers in the care sector deal with the values of affordability and client-centeredness in their daily management practices since the introduction of client-linked budgets?

In this article we first briefly explore the question whether healthcare managers feel comfortable or compromised managing different values. We then explain in more detail why client-linked budgets represent an interesting case to research the management of different values in practice. In the method section we describe how we conducted the interviews and analyzed recurring themes. In the results, we describe four modes of dealing with tensions between values that managers employ in their daily work with client-linked budgets. In the discussion and conclusion we reflect on the question whether managers feel they can enact 'good' healthcare management.

Dealing with different values: Feeling compromised or comfortable?

The responsibilities of operational healthcare managers at unit or location level have changed considerably since New Public Management (NPM) reforms in the healthcare sector. Due to the decentralization of managerial tasks and an increasing span of control, managers spend less time directly supervising healthcare workers and more time on managerial tasks such as budgeting, human resource management and the implementation of quality and accountability measures (Willmot 1998; Duffield & Franks 2001; Bolton 2003; Stoopendaal 2008; Actiz 2009).

This development has been described as shift from 'custodial management' to 'general management' (Bolton 2003; Young 2003). General management entails responsibilities for a broad variety of values: not only client-centeredness but also more businesslike values such as effectiveness, efficiency and accountability (Young 2003; Damhuis et al. 2003; Currie 2006; Elshout 2006; Hutchinson & Purcell 2010; McCallin & Frankson 2010). Consequently, managers have to take deal with many different values. A result of this broadened work scope is that operational managers with a professional background as healthcare worker provide less or no direct care

themselves anymore (Sambrook 2005; Stoopendaal 2008). Rather than doing physical work, they perform mental work that revolves around planning, coaching healthcare workers, attending meetings and implementing policy (Sambrook 2005).

Several authors notice that healthcare managers experience difficulties performing this new form of management. Firstly, managers with a professional background, especially nurse managers, can experience role conflicts when balancing the demands of the organization – such as efficiency and effectiveness – with those of individual patients (Hewison 1994). Moreover, they can dissociate themselves from the image of general manager by emphasizing their professional values about ‘good care’ (Bolton 2003; Wise 2007). Closely related to role conflict, is the concept of role ambiguity which refers to the lack of clarity about new management roles (McCallin & Frankson 2010).

Secondly, the broad responsibilities for sustaining quality, efficiency, safety and financial performance at unit level can cause anxiety and stress for several reasons. Managers experience a heavy workload and often lack the appropriate skills and competencies to perform a more businesslike, administrative role (Terzioglu 2006; McCallin & Frankson 2010; Hutchinson & Purcell 2010). Insecurity and anxiety can also manifest themselves when managers experience tensions between competing values of ‘good care’ and don’t know how to deal with these tensions (Van Hout 2006; Shirey et al. 2008; Cathcart et al. 2010). In its most extreme form, managers can experience moral distress when they are faced with conflicting values and demands. This means that managers feel constrained to do what they think is ethically right (Mitton et al. 2011).

While several authors stress the difficulties that operational healthcare managers experience, there are also signs of a more optimistic view. If operational healthcare managers feel supported within their organization, they can confidently function as boundary spanners that translate general policy ideas – about different values in healthcare – into context sensitive solutions and practices (Currie 2006). Furthermore, it is argued that by working collaboratively with healthcare workers, rivalry between the logic of business-like healthcare and professionalism can be managed successfully (Reay & Hinings 2009). An advantage of healthcare managers with a professional background is that can call on both caring and business rhetoric, which provides tactical maneuvering room and enhances their power to make their own value judgments (Young 2003).

Given these diverse views in literature on operational healthcare managers, it is necessary to gain a better understanding how they deal with concrete cases of different values in practice.

A case of different values: Client-linked budgets in the care sector

As recently as January 2009, the Dutch government introduced client-linked budgets to finance the long term care. This means that care organizations no longer receive an average compensation for every client, but only get paid for the hours of care they

provide to individual clients (Website Rijksoverheid). Despite initial statements that the new financing system would not be part of a policy of curtailment, the latest government proposals have stressed the need for budget cuts in order to keep the system of client-based financing affordable in the long run. Consequently, individual budgets for clients who receive intramural care ('weighted packages') are now being reformed which will have consequences for the financing of long term care facilities.

In this article we specifically focus on the so called 'weighted packages' for clients in intramural care, from now on referred to as client-linked budgets. The basic idea of this form of individual funding is that different budgets are assigned to clients on the basis of an assessment of their individual need of care. The allocated budget entitles clients to a certain amount of hours of care per week and compensates healthcare organizations accordingly. In the Dutch care sector there currently exist 52 different client-linked budgets, ranging from only a few hours of care per week to more than 30 hours per week (Website Rijksoverheid). Aside from the amount of hours, the different types of care that clients are entitled to are specified in the individual budgets, such as individual support or intensive care.

With the introduction of client-linked budgets the Dutch government intends to serve several goals. It is assumed that clients adopt a more active role as consumers. Within the boundaries of their individual budget, clients can make the choice how to spend their indicated hours of care. For example, they can decide to go on a daytrip with a supervisor, but can also use smaller chunks of supervision for weekly activities. Client-linked budgets are also seen as an instrument for clients to hold healthcare providers to account for the quality and quantity of care that is provided (Grit and Bont 2010). Healthcare organizations are obliged to draw up a 'care plan' for each client, which details the specific daily provision of care (for example how many minutes per day the clients receive assistance with showering or meals). This care plan can be seen as a contract which defines the care that clients are entitled to, but also makes clear the limits of the care that can be provided by healthcare organizations (Grit & Bont 2010; Zuiderent-Jerak et al. 2010).

Healthcare organizations are at the same time expected to make a better fit between the care they provide and the individual wishes of clients: not only because that is demanded of them in the new financial structure, but also because tailor made care can potentially attract new clients. The government also intends to make long term care affordable and economically sustainable in the long run. Client-linked budgets are seen as an instrument to manage the demand of care – and the costs that come with it – more explicitly. Care providers are discouraged to 'overcare', as in providing more than is indicated.

All in all, the Dutch government considers client-linked budgets an important vehicle to attain multiple goals at the same time: it aims to attain more client-centered, accountable and transparent care, while at the same time keeping costs in check. How does this policy work out in practice for operational healthcare managers?

Methods

Qualitative, semi-structured interviews were conducted with 16 operational healthcare managers that work in different healthcare organizations in the care sector in the Netherlands ranging from elderly care and care for the handicapped to care for homeless and addicted people. The working definition of healthcare manager that was adopted for the selection of interviewees was: managers that are hierarchically responsible supervising healthcare professionals and managing finances. All the managers that were interviewed had previously worked as a healthcare worker before becoming a manager. Their professional background varies, from nursing to social pedagogical work and care assistance. In addition to operational healthcare managers three higher managers, a personnel official and a team coordinator were interviewed as well to provide additional insights. Interviews lasted on average between an hour and 2 hours and a half. All interviews were fully transcribed. Interviewees were guaranteed anonymity, so that they could talk freely about their work.

Rather than asking specific questions about different notions of 'good care', thereby priming the interviewees to talk about values, managers were asked to describe 1) their career path and professional background, 2) how they spend their time on a typical working day, 3) their experiences of enjoyable and difficult aspects of their work, 4) their day-to-day decisions, 5) developments within healthcare that affected their day-to-day decisions. The semi-structured nature of the interviews allowed sufficient room for managers to engage in anecdotal stories about their daily work. Often these stories focused on the concrete tensions that they experienced when managing different values. By a process of inductive coding (Mortelmans 2007), key tensions and dilemmas between values were identified in the daily work of operational managers. In this article we have chosen to zoom in on the most persistent and recurring tension that managers struggle with: keeping care both affordable and client-centered care at the same time. The introduction of client-linked budgets was described by managers as an important development that influenced their day-to-day decisions concerning this tension. On the basis of further inductive coding, four modes of dealing with tensions between affordable and client-centered care were identified.

Results

In this section we first show that managers play an important role in operationalizing the values of affordable and client-centered care at unit or location level. We then describe the tensions that managers experience between affordability and client-centeredness. Subsequently, four modes of dealing with tensions are established: balancing values individually and collectively, prioritizing one value over the other, establishing compromises between values and making healthcare workers responsible for balancing different values.

Operationalizing values at location level

Since the introduction of client-linked budgets, the notion of affordability of care is increasingly interpreted as an individual responsibility of location and units, and less as a collective organizational responsibility. Managers stressed that they feel more responsible for keeping to their location budget, because the new finance system has made it more clear which locations perform well financially and which location have budget deficits (see also Zuiderent-Jerak et al. 2010). The responsibility for stricter budget keeping – on the basis of client-linked budgets – is not perceived as an easy task. Managers often describe themselves as ‘someone who is not interested in numbers and administration’ and ‘geared towards the human side’. Higher managers noticed that operational managers often lack the skills to make good business calculations on the basis of client-linked budgets. They also wondered whether operational managers are able to get a ‘helicopter view’ of all the interests at stake on location level. Several operational managers themselves mentioned that they struggle with getting a good overview, especially when it comes to matching flexible income (client-linked budgets) with expenditures (largely personnel costs, which are less flexible).

Due to client-linked budgets, most managers feel inclined to more strictly manage personnel costs. Several managers mentioned that a shift is taking place towards flexibilizing the employment of healthcare workers on the basis individual budgets. They tell healthcare workers that they can no longer work regular shifts, which is not always appreciated. Often managers have to work hard to turn around initial feelings of resistance. In order to keep care affordable on location level, managers also try to get a better fit between the level of indications (heavy/light indications) and the educational qualifications of healthcare workers. Some managers indicated that it becomes necessary to turn around the culture of healthcare workers of ‘doing things together’, by making a more explicit distributions of tasks.

Managers experience ‘mixed signals’ about how they should keep care affordable. On the one hand they are encouraged within their organizations to become more entrepreneurial: ‘good quality care’ and ‘a good reputation’ in the community can attract new clients and extra income. At the same time, operational managers are warned by higher managers to not automatically accept new clients at location level. Because of annual arrangements between healthcare organizations and the local care administration office, organizations only get compensated for the production that is contracted in advance. Operational healthcare managers therefore sometimes feel unsure which role they should perform: as implementer of central policy or as entrepreneurial manager.

Managers also reshape notions of client-centeredness working with client-linked budgets. A rather common interpretation that managers made of client-centeredness was ‘responding to the individual wishes of clients’, which are written down in the care plan. Managers however were quick to point out that this way of envisaging client-centeredness can create false expectations: “Care is not a matter of instant delivery” or “it’s not realistic to say: your wish is our command.” The impression can be created that every individual request can be met, whereas on location level it is not financially possible to provide fully individualized care. Managers therefore stated the

importance of expectation management and the need for more explicit conversations between clients and healthcare workers about making choices:

I think we need to engage more in conversation with our clients about his package and what he wants from us from that money (...). To lay down the options: "well, what do you want?" It's no longer the case that we can deliver everything; there we have to make choices.

Paradoxically, providing client-centered care can also mean saying 'no' clients when they express their demands. Not because of financial limitations, but because it would not serve the best interest of the client given their particular care needs. Saying no to a 'customer' with an individual budget can give an uncomfortable feeling, as becomes clear from the following statement of a manager:

It's an uncomfortable split. On the one hand someone is a customer and brings along a client-linked budget and so he has all kinds of desires and requests. And at the same time you are also the one that sometimes needs to say: "Well we can't deliver that (care, LO) taking into account the client's handicap." So you have a protecting role there too.

For managers another way of providing client-centered care is to temporarily tone down the importance of the indication as a distribution mechanism of care. Generally, managers emphasized their task to guarantee the continuity of care in the long run by sticking to the financial scope set by the indication of clients. Yet managers also underscored the importance of not sticking too rigidly to the indication. Especially when clients need more care due to unexpected circumstances, the distribution of care can be based on the need of clients, rather than on economic demand (the indication):

You have to also watch out that it's not becoming too business like. That client (...) had a rather tricky situation going on at his home in January and then he called more often and asked whether I could come around. Then we provide more hours of care than three to nine hours (indication, LO).

Dealing with tensions between different values

According to the Ministry client-linked budgets will lead to more affordable as well as client-centered care. Client-centeredness and affordability are seen as values that reinforce each other positively. From the viewpoint of the interviewed healthcare managers, client-linked budgets are not always considered a 'win-win' situation. Generally speaking, managers feel a tension between attaining affordable and client-centered care at the same time. Several managers phrased this tension as a dilemma. From a pragmatic standpoint, dealing with dilemmas is seen as 'part of your job' or 'just something you have to get on with'. However, managers frequently mentioned feelings of unease and discomfort, especially in situations where managers feel they have to 'nibble away' at the quality of care. Being officially responsible for both the qual-

ity of care and finances, can feel particularly uncomfortable for less business minded managers who have difficulty getting a grip on the numbers. Which different dealing modes do managers develop in practice to solve the perceived tensions between affordability and client-centeredness?

Balancing values collectively and individually

Several managers pointed out that it is difficult to live up to the promise of providing more individualized care. In fact, managers notice an increase in the provision of group-based care at their locations since the introduction of client-linked budgets. They mentioned that individualized, tailor made care can only be realized when the bulk of care is provided collectively. One healthcare manager, who manages different living facilities for handicapped clients, elaborates on this paradoxical turn of the new financing system:

With client based budgets you can really notice that you have to organize things collectively, what I just said. So you can focus less on the individual, whereas it was intended the other way around (...). Ok, so we are going to introduce client-linked budgets, but it has to be budget neutral. So, well guys, you know, with the same money that we have got we have to do it differently. Well, then you really can't provide more individual supervision (...). So, you have to somewhere organize things collectively, in order to be able to do the rest individually. So, in fact, for everybody collective meals, a few nights a week sitting together. Because otherwise you can't provide the other hours individually. So, is it often contradictory.

It is often ambivalent for managers whether they provide care on the basis of demand (responding to individual wishes of clients) or supply (organizing collective care arrangement because it's necessary to make budget cuts on location level). The decision to provide collective care – be it shared meals or communal evening activities – is usually made because managers feel the pressure to keep care affordable and 'stay out of the red numbers'. Generally speaking, keeping a healthy budget is not seen as a goal in itself, but is considered an important guarantee for the continuity of care in the long run. While the provision of collective care is often motivated by keeping a healthy budget, it can also be seen as a form of granting individual wishes, as clients sometimes do express the need for more social contact with other clients.

The balancing act between meeting individual wishes of clients and keeping care affordable through the means of group based care, gives managers a 'two faced' feeling, as becomes clear from the quote below:

Now we have created two facilities where people can spend the evening with each other two nights a week. That means that they don't get individual supervision, but that it's group based, which of course is cheaper. I have to say, it all feels very two-faced. Luck was on our side that in the meantime people had asked: "We want to do something together." I felt good about that, because in general we try to do things very individu-

ally because we see that people respond to it very well (...). And sometimes, you create supply to see whether there is demand, but in principal it's on the basis of demand. So this is all very double to me, because we now open up these facilities because we have to cut back on hours. So we are going to make sure that those evenings are as much fun as possible.

The provision of group-based care makes it possible to provide expensive types of care such as supervision during the night, which can't be delivered on the bases of one budget of an individual client. Collective sharing of these services is therefore necessary, but sometimes sits uncomfortably with the notions of individual rights and entitlements to care. Although not all clients are able to adopt the role of critical consumer, some family members insist on getting their 'due share' of care by referring to their individually assigned budget:

Often clients aren't even that conscious of their rights and think: Well, it will be ok. Whereas parents and family more often say: "No, but that employee is on holiday, is there someone else coming? How do we handle that?" Or, when we aren't around for three weeks, "Can we get those hours back afterwards?"

The provision of more group based also has important consequences for the scale of locations where clients live. In order to be able to provide group based care – and ensure the affordability of care within the setting of client-linked budgets – locations need to have a certain size. This however puts pressure on the ideal of small scale living facilities, which is seen as a form of client-centered care. Several managers mentioned that they felt a tension between realizing the strategic vision of their organization about small scale living arrangements and the practice of keeping small scale facilities profitable. This tension was especially felt by organizations that provided care for people with a handicap. Compared to healthcare providers in elderly care, these organizations usually have a longer history with small scale living facilities that are based in residential areas. As becomes clear from the following quote of a troubled manager, it often feels like a dilemma to enact the ideal of small scale care arrangements and ensure affordability of care on location level:

I have a couple of unprofitable locations. Once a choice was made to start up these locations. For example, a location where we have six clients who live there, the youngest is 16 en the oldest is 22. These are people who need constant supervision because they are very vulnerable and can be easily influenced. You can't leave them alone at that location. Maybe just for an hour or so, that you tell them: "I am going to do groceries and we will be back soon and you have a mobile so you can call me." But you can't leave them for a day, also not at night. But with six clients you can't provide night supervision. We used to be able to do that with ten clients. Now, they say, you need at least fifteen clients together. So you need fifteen clients to be able to provide supervision during the night. But we do have that location! So you can't just say: "Well guys, too bad, we can no longer provide night supervision." So, these are the strategic choices that I am very much struggling

with at the moment, because I also find it a dilemma. I see a very big budget deficit and that deficit is only rising and it needs to be paid somehow. But on the other side I also see that those clients, well it can all be figured out that way, but you can't leave them alone.

Different solutions were mentioned by managers to cope with this dilemma, ranging from scaling up locations by taking on extra clients, strategically choosing clients with a high indication of care, temporarily putting up with less quality of care (for example sharing a supervisor between several location in combination with the use of baby phones during the night), closing down unprofitable locations or – the opposite – running up a budget deficit. A strategic option that was mentioned more frequently than others was the selection of clients with 'high' indications, which guaranteed more income. Some managers realized however that this is not an uncomplicated strategy. So called 'difficult' clients, who need more care than others, can disturb the existing group dynamics. When this happens, extra supervision is needed, which defeats the original purpose of creating more financial leeway in the budget:

You have to fill up (open spaces, LO) as quickly as possible. On the other side, you want there to be a good fit with other clients that you have. You can think: gosh, I want someone who has a lot of behavioural problems, because that brings lot of money, a weighted package 7, or something like that. You think: yes, that is the one I need, that produces money. But well, that's also asking for trouble. Soon you need extra supervision because you can't do it with the money that you..., that it doesn't have a bad impact on the other clients.

Prioritizing one value over the other

Several managers mentioned that they increasingly felt pressures to prioritize the value of affordable care to prevent budget deficits on location level. This need becomes apparent in several examples from practice. A recurring example of prioritizing affordable care is the provision of more group-based care such as communal evening activities. When managers need to 'cut back hours' because of budget deficits the option of group based care becomes more attractive. 'Scaling up' locations or units by taking on extra clients is also a strategy that is adopted more often. Managers are aware of the extra workload they put on the shoulders of healthcare workers and the danger of giving less personal attention to clients, but feel an even greater responsibility to guarantee the continuity of care in the long run by avoiding budget deficits. Another recurrent example of prioritizing affordable care is strategically taking on clients with a high indication. Managers are also forced to say 'no' to new clients who are expected to put a burden on the budget because they probably need more supervision than is indicated for in their individual budget. This gives managers an uncomfortable feeling:

He has a weighted package 3. Well, in principle that could work for that location. But I would have to employ more hours, but I can't do that, because I don't have the money

for it. So in the end, I have to turn him down (...). If he were to live there, it would all go terribly wrong. But I don't have any other places for him either.

Despite increasing pressures to manage with a tight budget, managers try to create flexibility in the new financing system. This is the case when they temporarily tone down the importance of indications when clients unexpectedly need more care than their indication allows for. Examples that were mentioned during the interviews mostly concerned emergencies, such as extra supervision during hospital stays and sudden mental break downs of clients. On a more structural basis, some managers run up budget deficits because they choose to provide a certain quality of care they deem necessary for their clients (such as supervision during the night). On the one hand, a (large) budget deficit can be seen as a sign of financial mismanagement. On the other hand, it can also be interpreted as an attempt to sustain a certain level of good care.

From an organizational point of view, some allowances can be made when managers can properly account for these deficits on their location. Several managers mentioned that it is good practice to help out locations that are in financial need by reshuffling the central budget that is reserved for general investments. Some managers phrased this as 'solving things together, collectively' and 'practicing solidarity'. However, with the new financing system responsibilities for budgets are partly being decentralized to unit and location level. This means that locations more and more become their own 'independent shops', financed by the individual budgets of their own clients. Financially bad performing locations, who very well might be providing client-centered care to a complex group of clients, therefore need to negotiate more with other locations to take up part of their deficit.

Establishing compromises between values

Often managers try to establish compromises between affordability and client-centeredness. An example of such a compromise is the development of individual apartments under 'one roof' with communal living rooms, which facilitates the provision of individual as well as group-based care. This way, care can be affordable and client-centered by creating a balance between the clients need for privacy as well as their need for social contact with other clients:

What we see with the construction of new houses it that we try to look for good 'in between' forms. For example in X (name of place left out, LO), there we are busy with an initiative from parents. So people have their own apartments under one roof, but with two big communal living rooms. That is ideal really.

Another recurrent compromise is the involvement of volunteers, interns and family members in the provision of care. Especially when there is a shortage of personnel, due to sick leave, managers try to sustain the quality of care by recruiting volunteers and interns. A manager who works with homeless people and clients with an addiction

stresses the need to think outside the box in order to meet contradictory demands from 'the top' and 'the bottom':

At the top you have a budget and a regional manager who just wants you to stay within the budget, that's that. And if there is no money left, there is no money. At the bottom they want...there is a high health related absenteeism at your unit. They don't want to work with considerably less people on the work floor and have to work twice as hard. They want you to get temporary workers (...). There is a tension there, because they cost a lot of money, which means that I can't keep to the budget (...). I always solve this by looking at it differently, so which solutions are there which meet both wishes? So I try to work with a lot of interns and volunteers.

Increasingly managers point out to clients and their family members that client-linked budgets have very real consequences for the care that can or cannot be provided:

Well yes, there are regulations from the top; we haven't chosen those weighted packages. And the financial picture that comes with it we haven't chosen either. Within our region, within the city, our regional manager has also organized an information meeting for family, so they can be taking along with the fact that this has consequences for the care that can be delivered.

By framing care as a shared responsibility of the social network which surrounds the client, managers try to transfer some of the responsibilities of care to family members and friends of clients. When the client's social network is limited volunteers are actively recruited. By doing so, 'good caring' is being redefined. Healthcare workers should not automatically provide care themselves, but should 'take care' that other parties take up part of the responsibility of care:

Look, we can provide bed, bath and bread. But if the client wants to cycle for an afternoon or evening, then it's very dependent on the client, but we will look for a volunteer. Is there someone in the network [of the client, LO]? Does that person have a network at all? Are we going to invest...is that supervisor 1 going to invest in cycling, then those hours (of care, LO) are depleted immediately. Or is this supervisor 1 going to invest in one hour of cycling and one hour of looking for someone, together with the client, that can structurally provide that. Look, that is the dynamic what it is supposed to be all about.

Managers not only reframe what good caring by healthcare workers should be, but also demarcate what 'care' actually is. Due to client-linked budgets managers feel the need to explicitly demarcate boundaries between 'basic care' ('bed, bath and bread'), and 'extra care' which falls into the realm of 'well-being' and can be provided by volunteers and interns.

Making care givers responsible for balancing values

Managers increasingly frame the balancing act between affordable and client-centered care as a 'shared responsibility' between managers and care givers. They ask their team to come up with 'creative solutions' for keeping finances in check while at the same organizing care arrangements that meet the preferences of clients:

When I am told "You need to cut back 36 hours at your location", I directly sit down with employees, inform them and take them along in the process. And I tell...let them think about how things can be done differently. And that they are going to think about their tasks, the way they supervise, how they do it and their time investment. In order they are directly involved in conversation with the customer: "gosh, you know, I used to be there for you two hours a week, but from this moment I will be coming for one hour. How are you going to use that hour? How are we going to do it? What do you really need? And what could you do yourself and what can you do together, for example, with your mother or your neighbor?" Do you get it? That there is continuous line. And that is fundamentally different. Previously supervisors had to do that less often and I to say that less often, because we had a lot more space and time.

Making care givers responsible for balancing affordable care and client-centered care, is sometimes experienced as struggle by managers. The distribution of care on the basis of daily need can conflict with the distribution of care on the basis of an indication/client-linked budget:

We struggle in our role as team leader with the fact that these girls that are on the work floor day in day out want to provide the best care, whether it fits the care package or not. As soon as that lady asks a question, they are going to answer that question or they are going to look for a solution and they are not going to think whether that lady has an indication for that.

By emphasizing that a professional attitude not only entails 'caring for' clients in the physical sense, but also 'taking care of' financial and administrative matters concerning client-linked budgets, managers reframe what professional work should be about:

Instead of just continuing giving care and doing your best, caring from your genes and your heart, now they also have to become more conscious that it costs money and that you need an indication and that the indication is perhaps too low at the moment. You have to look whether the means, the weighted package of the client, can be increased. And that second step I think is a logical one. That wasn't a logical step because you used to do your utmost best and there was money and you just had to make do.

The inclusion of affordability criteria *within* professional notions of what good care should be, seems a logical step to more businesslike minded managers. Not all managers however feel comfortable with this trend. Some emphasize that they can relate to

the inclination of healthcare workers to respond to the daily requests of care, whether or not that fits with the requirements of client-linked budgets. During the interviews managers frequently referred back to their own background as a care giver in terms of having a “care-DNA,” being a “people minded person,” “having a strong sense of involvement.” Some managers, especially those that have worked in healthcare for a long time, wonder whether their personal sense of involvement doesn’t stand in the way of a more businesslike approach towards care:

Of course I am someone from the older generation, a high commitment level you know. At some point that’s in your genes (...). Even if I become a hundred years old, I am not going to lose that. You can consider it a quality, but at the same time it’s a trap as well. And, does it still suit the contemporary organization, you know? And, uh, but well, I am still here.

Gradually you see unit leaders from the younger generation, that the younger generations are taking up management roles. They all have a hart which is geared towards the human side, but many managers are also much more businesslike. So, far more like cut to the chase.

Discussion

Our findings show that operational healthcare managers play an important role in operationalizing the generally framed policy goals of client-linked budgets into locally sensitive practices. Consistent with Curries’ (2006) notion of boundary spanner, operational managers translate and reframe the meaning of affordability and client-centeredness at location and unit level and create modes of dealing with tensions between values in the context of the new financing system. Client-centeredness is reshaped by managers from a more *reactive* response of granting wishes of clients to a process of *active* negotiation between clients and care givers about what care can be provided within the limits of the location budget. Interestingly, operationalizing what affordable care actually means on location and unit level is less straightforward than the policy intentions of client-linked budgets imply. Managers receive mixed signals how to keep care affordable. While they are encouraged to act as entrepreneurs by managing their own budgets and attracting new clients and income, they are also advised to stick to collective production ceilings of their organization. Operational healthcare managers therefore seem unsure which role to perform, balancing between a more entrepreneurial role and the role of implementer of central policy. These findings seem to suggest that role ambiguity is not just a concept that applies to nurse managers in hospitals (Hewison 1994; McCallin & Frankson 2010), but can also be extended to operational healthcare managers in the care sector, who have a more varied professional background.

In the existing literature on operational healthcare managers, feelings of unease, anxiety and stress have been linked to an increased work load (Hutchinson & Purcell 2010), a lack of management training and business skills (Terzioglu 2006; McCallin

& Frankson 2010) and difficulties handling tensions between competing values of good care (Van Hout 2006; Shirey et al. 2008; Cathcart et al. 2010; Mitton et al. 2010). In our study managers reported feelings of insecurity about managing their location budget on the basis of client-linked budgets. Especially matching flexible income (client-linked budgets) with costs (mainly personnel costs, which are only flexible to a certain extent) is not an easy task. They also described feelings of discomfort being responsible for a tight budget on the basis of client-linked budgets and the provision of good quality care. Within nurse management literature, several authors propose to solve these difficulties and feelings of insecurity by stressing the need for courses on business skills and management development (Terzioglu 2006; Hutchinson & Purcell 2010; McCallin & Frankson 2010). Although we can imagine that courses on business skills can give useful insights, we question whether this solution can resolve the ambivalence and insecurities of managers about their own performance and their enactment of 'good' healthcare management.

Our four modes of dealing with tensions between values show that the daily practices of healthcare managers are full of inherent complexities, resulting from conflicting conceptions of good care. To suggest that feelings of insecurity and ambivalence are solely the result of lacking skills and competencies, would place too heavy a burden on the shoulders of individual healthcare managers. More importantly, a toolkit of budgeting techniques and business skills would obscure the fact that healthcare managers have to deal with 'varieties of goodness' at the same time. A location budget that is efficiently managed on the basis of client-linked budgets, doesn't necessarily count as 'good' healthcare management. When other 'goods' are not taking into account, it might even be called 'bad' healthcare management.

We therefore stress the need for operational healthcare managers to become more reflexive and mindful about the ethical dimensions of every day decisions (Laroche 2009; Valentine et al. 2010). This is important because in the current financing system managers feel compromised in enacting what they think is 'good' healthcare management. When managers run up financial deficits at their location, they increasingly feel forced to say 'no' to clients with 'low indications', or the other way around, attract clients with 'high indications'. Several managers also feel 'two faced' about the development of scaling up locations and providing more group based care to keep care affordable for individual clients. As the practice of financial solidarity *between* locations is becoming less self-evident because of individual entitlements of clients to budgets, the above solutions can become more of a reality at location level. Managers do create flexibility in the financing system by making healthcare workers responsible for creative solutions and by reframing the responsibility for care as a broader responsibility of the network around clients, but these solutions in themselves also create new questions about how to appropriately balance between involving other parties and not burdening them too much.

Given the ambivalent, 'two-faced' feelings several operational healthcare managers experience when confronted with value tensions in their daily practices, we recommend further research that explores the relevance of the concept of moral distress in relation to healthcare management. This concept has been widely used to describe

feelings of distress that healthcare professionals experience in their work when they are prevented from delivering the care that they deem necessary professionally or personally (Milton et al. 2010). Although this concept has recently been applied to hospital managers at higher and mid-levels (Ibid.), it seems useful to further explore whether moral distress is also experienced at the operational level of management in less clinical settings, such as the care sector.

Conclusion

Our findings show that the world of operational healthcare managers is ambivalent and full of shifting tensions between different values. Rather than just leaving it at that, we wanted to understand how operational healthcare managers actually deal with tensions between affordable and client-centered care since the introduction of client-linked budgets. We identified four modes of dealing with these tensions in practice: 1) balancing values individually and collectively, 2) prioritizing one value over the other, 3) establishing compromises between values and 4) making healthcare workers responsible for balancing different values.

Managers find themselves balancing between the promise of individualized care and keeping care affordable in the long run by the provision of collective care in groups. In order to be able to give individual supervision to clients, which is an important goal of client-linked budgets, managers need to provide more group based care. Only when clients share certain types of care together, it is possible to keep care affordable on location level. This sometimes sits uncomfortably with the idea of individual entitlements to care. It also puts pressure on the ideal of small scale living facilities. Managers therefore also balance between keeping care affordable through group-based care and not giving up ideals of small scale care. Increasingly managers feel pressured to prioritize affordability of care, when they run up budget deficits. Several solutions for keeping care affordable were mentioned such as scaling up locations, taking on new clients with high indications and flexibilizing shifts of healthcare workers. To lift some of this pressure, managers try to create flexibility within the new financing system by creating compromises such as living facilities that enable individualized as well as collective care. Recruiting volunteers and interns is another recurrent compromise between client-centered and affordable care. In addition, by framing care as a shared responsibility of the social network of the client, managers try to transfer some of the responsibilities of care to family members and friends of clients, thereby keeping care affordable in the long run. Last but not least, managers increasingly frame the balancing act between different values as a shared responsibility with healthcare workers. They ask care givers to come up with creative solutions themselves. The nature of the work of care givers is thereby changing too. Managers emphasize that a professional attitude not only entails 'caring for' clients in the physical sense, but also 'taking care of' financial and administrative matters.

This story about dealing modes is not a 'value free' story about technical managing in healthcare. We hope to have shown that the daily practices of operational healthcare

managers entail different ways of dealing with every day normative issues which have a very real effect on the quality of care. It is therefore necessary to raise more awareness for the specific moral problems that operational healthcare managers experience in their work.

Note

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We would like to thank the participants of the conference 'Ethics, Health Care and Anthropology' and our colleagues of the section Healthcare Governance for comments on the first draft of this article. Special thanks go to Annemiek Stoopendaal, Rik Wehrens and Roland Bal for their suggestions to improve the article.

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