Explaining System-level Change in Welfare Governance: The Role of Policy Indeterminacy and Concatenations of Social Mechanisms

Edoardo Ongaro, Open University, UK and *Francesco Longo,* Bocconi University, Italy

Abstract

The paper argues that a certain level of indeterminacy in policy design may be a factor facilitating rather than hindering system-level change in welfare governance arrangements, provided it is combined with the triggering of specific concatenations of social mechanisms shaping the dynamics of the change process. The argument is illustrated by an analysis of a case of systemic change in chronic disease management occurred in the Italian region of Lombardy over 2016-2017, when a radically novel governance of chronic disease for the ten-million population was put in place (a health care system that was later tested to its limits by the COVID-19 pandemic outburst which reached dramatic intensity in this region). This represented a major change in a key area of social and health policy. We claim that such change processes may be studied by means of the conceptual tools of social mechanisms. The analysis of social mechanisms represents a lively research agenda for explaining change in public governance and public policy.

Keywords: systemic change; social mechanisms; policy design; policy indeterminacy; chronic disease management; social and health policy.

1. INTRODUCTION AND RATIONALE

In this paper we argue that a certain level of *indeterminacy* in policy design (indeterminacy of policy objectives and contents, of formal planning of the change management process, of the expected give-and-take balance for the main stakeholders) may be a factor facilitating rather than hindering system-level change, provided the management of change is based on actors' agency that, combining with

context features, leads to the triggering of concatenations of social mechanisms affecting the inner dynamics of the change process. The key message of our study is that system-level change can happen also without being directly produced by the design of the policy; indeed, some vagueness in the policy design may open up opportunities for actors to interact and effect change at later stages of the policy process. The causal textures of the dynamics of the policy process may be read through the theoretical lens of the analysis of the activation of combination of social mechanisms as a form of mid-range theorising about the dynamics of system-level change process under conditions of indeterminacy of the policy design. This work aims at shedding light on such concatenations of social mechanisms and their interplay with indeterminacy in policy design, by drawing on the analysis of a case of systemic change in chronic disease management in the Italian region of Lombardy occurred over 2016-2017, when a radically novel governance of chronic disease for the ten-million population of the region was put in place (the health care system of this region that was later tested to its limits by the COVID-19 pandemic outburst which reached dramatic intensity here, though this event is analytically unrelated to the episode of system-level change recounted in this contribution).

In the case observed, policymakers' focus has been the legal enactment of the reform bill – mostly consisting of relatively broad-scope and vague prescriptions about institutional and service innovations to tackle the growing epidemiological shift from acute to chronic needs – coupled with some extensive political story telling ('selling the reform') and the setting up of venues for continuous and adaptive interactions with stakeholders. The starting point of our analysis is the observation that the prescriptions of the reform were quite vague and potentially conducive to limited change, or to outcomes profoundly different from the ones observed, and there is evidence of policy-makers dithering in their stances on both the ends of the reform and the means to achieve it: quite plainly, the design of the reform was akin to a recipe for limited and at most fragmentary change. Still, substantive systemic change in the governance of the welfare for long-term illness actually occurred, and intended and unintended processes determined such level of change. We claim that such processes may be

studied by means of the conceptual tools of the social mechanisms, a form of mid-level theorising for the explanation of social phenomena, whose usage for explaining specifically policy and administrative change has been advocated by leading scholars in the field of public policy and management (see recently two collective efforts led by Howlett, Ramesh, and Capano: Capano at al,, 2019 and forthcoming).

In this paper we advance this research agenda aimed to explore the explanatory power of social mechanisms in public policy and administration specifically when applied to innovation in the governance of the welfare and to systemic change, which we consider as a specific type of change. We aim to contribute to the analysis of social mechanisms as a broad research agenda carried out collectively by a range of prominent scholars in sociology in general and public policy more specifically (like Barzelay, Gallego, Hedstrom or Swedberg – see Barzelay, 2003; Barzelay and Campbell, 2003: Barzelay and Gallego, 2006 and 2010; Hedstrom and Swedberg, 1998) by making a contribution specifically to bettering our understanding of what specific concatenations of social mechanisms may explain system-level change under conditions of indeterminacy of the policy design. We define system-level change as change occurring in both the rules and the organisation of the delivery of a public policy.

In particular, we challenge the notion of the policy designers' purposeful social action in interaction with deliberate policy design as the decisive factors, and emphasise the functions performed by the triggering of social mechanisms in affecting the outcomes of a change process of the public governance in a given area of public services. Under certain context conditions, the triggering of concatenations of social mechanisms may perform key functions in the process of change, to a significant extent irrespective of and beyond the deliberations of policy designers, while other social actors' agency may perform a relevant role in the change process. As regards the way in which we operationalise the notion, we use the notion of 'policy indeterminacy' to refer to a design

of the contents of the policy (the reform package) characterised by, first, vagueness of the prescriptions contained such that radically different outcomes could ensue from these contents while the claim can be upheld that prescriptions have been met, and, second, such that the reform package refers to the adoption of provisions to be taken subsequently to substantiate and detail the exact contents of the reform. It may be queried the extent to which policy indeterminacy can be operationalised as a gradation, or to what extent it is a binary condition. Our, at least tentative, answer to this pertinent question is that policy indeterminacy, whilst it can indeed be seen as a gradation, ultimately can be treated as a binary condition for the purposes of delineating the contours of the domain of applicability of the findings of our study. Accordingly, we would consider most public policies, and even more so in sectors where technical knowledge and expertise is a key factor as is the case of the healthcare sector, to be generally characterised by 'determinacy' of the policy design, and yet there are instances in which the level of indeterminacy is so relevant to enable classifying it as "high" on policy indeterminacy – and this condition may open us a set of process dynamics which differ from the (more common) circumstances under which this is not the case. This is what we investigate in this study (it may be noticed for clarity that this conceptualization of the term 'indeterminacy' is altogether different from definitions in economics to refer to non-calculability or non-determination of the value of a variable).

Our *research question* concerns how can system-level change to the welfare system under conditions of indeterminacy of the policy design be explained, and our tentative answer is that the analysis of the triggering of certain concatenations of social mechanisms as specified in this paper and shedding light on how developmental patterns of change may unfold (de Ven and Poole, 1990) provide a valuable repertoire of conceptual tools to this purpose. Our empirical question is explaining the change process that occurred in chronic disease management in the case of the Italian region of Lombardy. Finally, we envisage our broader contribution to lie in contributing to research agendas aimed at explaining policy and administrative change (as a subset of broader processes of social

change), and in producing a form of utilisable knowledge for effective change management in welfare governance and public governance at large.

The paper is structured in seven sections: following the present introduction to the argument, section 2 reviews selectively the literature on social mechanisms and, where directly pertinent to the purposes of this contribution, the literature on the policy process; section 3 discusses methods; section 4 then provides the case study evidence; section 5 examines the dynamics that led to the kind of stakeholders engagement that has enabled systemic change; the role of a certain concatenation of social mechanisms for explaining change is discussed in section 6; the final section wraps up on the findings.

2 THEORY: THE ANALYSIS OF SOCIAL MECHANISMS AS CONCEPTUAL TOOLS FOR EXPLAINING CHANGE

We adopt the analysis of social mechanisms as the centrepiece of the analytical apparatus. Social mechanisms can be defined as conceptual tools for the analysis of complex change processes. The analysis of social mechanisms is an approach to reveal the multiple causes of change through context-sensitive accounts (Pettigrew, 1990; Pollitt, 2013; Ongaro, 2013b) and specifying the social 'cogs and wheels' of investigated phenomena (Elster, 1993, p.3), an approach with a long history in the social sciences (Merton, 1968) and application largely in the field of sociology and only more cursory and intermittent in applied social sciences like organisation studies and public management, possibly also due to a relative disconnect with the mainstream frames adopted in these applied fields (exceptions include Barzelay, 2003, Barzelay and Gallego, 2006 and 2010; Capano et al., 2019).

Social mechanisms can be defined as 'unobserved analytical constructs that provide hypothetical links between observable events' (Hedstrom and Swedberg, 1998, p.7). Elster (1989 and 1998) and Stinchcombe (1991) interpret social mechanisms as building blocks for an advocated middle-range

theorising which can enable a revitalisation of the study of social phenomena by getting beyond covariation between variables or events, and rather aiming at investigating the causal texture of social phenomena. This approach has strong roots in sociology, as illustrated by Boudon (1991, revisiting the work of Merton, 1968, pp.43-44 in particular). Scholars in the field of public governance and public policy and management argue for the renewed significance of the analysis of social mechanisms for the study of institutional, policy and administrative change (Capano et al., 2019; Ongaro, 2019). It is generally a concatenation of mechanisms that enables the explanation of change processes (Gambetta, 1998, p. 105), as '[E]xplanations of most concrete social events or states require resort to several elementary mechanisms; one is not enough. Sometimes, these mechanisms counteract one another, and sometimes they work together' (Hedstrom and Swedberg, 1998, p. 21). Social processes (McAdam et al., p.24) are in this perspective seen as concatenations of such mechanisms.

In particular, the analysis carried out in this article uncovered the triggering of certain social mechanisms for explaining the process of systemic change observed in the Lombardy case of chronic disease management, and notably a set of social mechanisms able to explain how key stakeholders got engaged and sustained momentum of the change process. In particular, we hypothesise the triggering of the mechanisms of: actor certification, attribution of opportunity and threats, appropriation of mobilising structures, and band wagon effect, and we argue that the combination of these mechanisms may explain the unfolding of the process of systemic change that we observed, and that may be puzzling when factoring in the vagueness of the policy design.

The *mechanism of actor certification* refers to the validation of actors, of their performances and their claims by external authorities (McAdam *et al.*, 2001, p. 121). The mechanism of *attribution of opportunity and threat* can be defined as an activating mechanism responsible for the mobilisation of previously inert social groups which involves (a) invention or importation and (b) diffusion of a

shared definition concerning alterations in the likely consequences of possible actions undertaken by some 'political' actors (McAdam, Tarrow and Tilly, 2001, p. 43 and 95). The *appropriation of mobilising structures* refers to social spaces put at the service of interpretations of situations and objectives that may be employed to mobilise actors towards certain courses of action (McAdam et al., 2001, p. 102). *Band wagon effect* is the mechanism whereby it becomes more convenient to join (or at least be seen to join) a given social process (notably, the process of reform) rather than being side-lined and hence inhibited to enjoy the benefits if the outcome of the process turns out to be favourable.

In the public policy and public management literature, the most prominent applications of the analysis of social mechanisms have been focused on the 'policy of public management change', and related fields like 'public administration innovation' and 'decentralisation and devolution in the public sector', which has been investigated in a series of works (see the special issue edited by Barzelay and Gallego, 2010, and the related theoretical groundwork in Barzelay, 2003 and Barzelay and Gallego, 2010: on the policy dynamics of innovation in public administration, Mele, 2010; on decentralisation, Asquer, 2012 and Ongaro, 2006). In a related work, Barzelay and Campbell have investigated the dynamics of strategy change in a large public organisation (namely the US Air Force and its envisioning process). What seems to be lacking in the extant literature in public policy and administration is the study of system-level change, and applications of the analysis of social mechanisms to the field of welfare administration, a gap this contribution aims to fill.

3 RESEARCH DESIGN AND METHODS

The research design is a single longitudinal case study and the selected case is the systemic change occurred in the Region of Lombardy in Italy to implement the new chronic care model, universalist in thrust (the healthcare model is applied potentially to any patient in chronic condition resident in

the region, and for any type of illness: an estimate of 3.350.000 target patients out of ten million residents). The period of observation is from January 2016 to December 2017.

We emphasise the nature of theory building case of the selected case study, a usage in line with consolidated research, as outlined by case study methodologists like Yin (Yin, 2018); we should add our aim is more modest, and we would qualify this study as 'model building', or mid-range theorising approach, whereby we aim to elaborate warranted claims about the dynamics whereby systemic-level change processes may unfold under conditions of policy indeterminacy, notably with reference to the welfare sector. Case selection has been driven by the nature of the case, notably the characteristic of the case providing an instance of system-wide change, combined with the opportunity (complementary criterion of 'opportunistic considerations') of the vast accessibility we were granted to the multiple sites where and when the change process unfolded. Our main unit of analysis has been the change process, and in this Eisenhardt (1989) has been a guiding scholar.

The advisory role was run by a network of three Universities, including a team of 9 researchers, who worked as an integrated research group. There was one coordinator per university team – one of them being a co-author of this article, the other two having commented on earlier draft of this paper for validation and approval. Access to administrative data and to all the relevant stakeholders was enabled by the strategic advisory role granted to the research team. Collected evidence was always first discussed within the research team, then presented and analysed with different local stakeholder groups, and finally re-presented to the regional policymaking body, thus gaining a deeper understanding of different stakeholders' perspectives.

The official administrative data recorded for the innovation project we had access to included: minutes of all official stakeholders meetings (both at central and local level, as describe more in detail in the narrative); the list of General Physicians (GPs) and privately contracted providers agreeing to the new scheme and the related signed contracts (also the list of those opposed to the new scheme); the regional planning and regulatory documents, both in their initial draft versions and their various modifications from bills to the finally adopted acts.

The research team was involved across all phases of the policy process and was able to attend the negotiation rounds led by the Regional Government with the different stakeholders: public health care organizations, private contracted hospitals, nursing homes providers, GP associations and unions. The discussions occurred both at the central regional level, mostly about general principles and the regulatory framework, and at local level in the eight local territorial planning areas in which the regional health care system was partitioned. The combined team was present at central level discussions with the stakeholders, while each of the three universities worked as the local advisor in two or three out of eight local planning areas.

Data collection included a combination of: participant observation (as advisors to the regional government and trainers to local groupings); direct observations (at stakeholders meetings); interviews. More in detail, during the observation period, there have been seven official meetings at the central level between the regional Government policymaker and the research team (in average they lasted two hours), to discuss regional plans and proposals or research reports before presenting them to stakeholders. The regional policymaking group was of mixed nature including both politicians and top managers. A draft paper was always presented at the beginning of the panel and a new version was provided a few days later. The researcher role was rather active as discussant of the policy proposals or ex post collected evidences. Over the same period, regional policymaker run twelve stakeholders meetings (at these meetings the research team was present in an observer role), some sectoral with a specific category of stakeholders, others across the board; meetings lasted on average 2.5 to 3 hours; stakeholders meetings occurred in four waves during the 2017-2018 period, at every fundamental policy change or detailing step.

Each university also run three training rounds in every assigned local planning area, with all the different stakeholders' technicians as participant. The first round was focused on the health care context analysis and the premises of the reform, the second to present the reform and the third to discuss organizational and operational consequences. Every round was divided in three panels (public organization, private ones, primary care actors) and lasted one and a half day.

Additionally, four research focus groups with all the top managers and project team members of the eight local health organizations in which the regional territory was split were set up, which lasted three hours each, centred on the analysis of the criticism and strength faced by public health organizations to implement the reform. The panel of organizations were divided in two different groups, each one with four public health care organizations. The first focus group was, in both cases, about organizational issues and the second one about operational problems to implement the new chronic care model. Each health care provider was represented on average by five people, the top professional of each project team, led by one of the top managers (director general or health care director or integrated care director). The role of one of the authors of this paper was to moderate the focus groups; minutes of the focus groups were taken, both for research purposes and to report to the regional government.

The investigators were further granted access to most of the relevant social and professional events in the larger stakeholders arena, including: a panel discussion of the association of private contracted healthcare providers (an event which proved crucial for the forging of a common position towards the reform by this important group of stakeholders); the paediatric union board meeting, where it was discussed and decided how to react jointly to the reform as a homogeneous professional group; an open conference on the topic held by the major opposition party, an event which proved important for the unfolding of the events; and two official regional conferences to launch the reform. Finally, frequent informal and individual interactions with a wide range of actors (with a special focus on top managers of five of the biggest private health care holdings) in the policy process occurred, either face to face or on the phone.

4. THE NEW CHRONIC CARE MODEL IN LOMBARDY

Background: the management of chronic diseases in the aging population of Europe and Italy

In Europe an average 30-40% of the populations suffers of chronic diseases due to increasing aging, and almost half of them live under multi-morbidity conditions, covering 70% or more of health care expenditures (Wyke, 2011). Chronic diseases require a completely different approach and set of services compared to traditional hospital acute care. Patients need to be treated over many years and the best possible outcome is slowing down the deterioration process (least bad). Most of the treatments are assumed alone by patients, outside formalized care settings, and so patients' compliance becomes crucial. In this perspective understanding who the key actor for patient compliance is becomes crucial: it may be the patient him/herself, his/her partner, a child, friends or neighbours or a privately paid caregivers. Fostering patients' compliance is a core task of the chronic care case management function.

Most of the chronic conditions may be detected in advance, correlating to each patient her/his set of chronic illnesses and stages (Bates et al., 2014). A chronic condition requires intense interactions amongst different specialists and other staff because multi-morbidity is prevalent and clinical synthesis is more effective than the sum of single specialized treatments. Addressing simultaneously all challenges together (permanent treatments, patient autonomy and compliance, proactive medicine, interdisciplinary work) demands a radical change in the organizational and service model as well as in the professional skills and the associated technical, professional and social competences and attitudes. Many health care systems, both at local and national level, have therefore undertaken large scale experimentations to adopt new complex institutional and organizational approaches, which are generally classified under the umbrella label of chronic care management or disease management (Nolte, Knai, & Saltman, 2014). Systemic change brings with it formidable change management challenges, due to the scale of change (system wide), the shift in the underlying paradigmatic approach (from reactive to proactive medicine) as well as in the locus of the services (ambulatory care instead of acute care), the different emphasis in the skills required (the clinical synthesiser takes

prevalence over the specialist), the rise of new roles (case managers) and the introduction of new performance metrics (clinical adherence and patient compliance instead of productivity).

Lombardy: geographical and economic context

Lombardy, located in the north of the country, is the wealthiest Italian region per GDP and by far the largest per population with over 10 million residents, with Milan as capital city and 3,1 million residents in its metropolitan area. A significant percentage amounting to 33,5% of the residents are in some form of chronic condition, and they have been classified into three clusters, the green ones (1.9 mil) with one illness, the yellow ones (1.3 mil) with 2 to 3 illness and the red ones (0.15 mil) with more than 4 diseases (Lombardy Region: DGR 6164/2017).

The institutional and political context

The Italian National Health Service (NHS) is a decentralized Beveridge model with strong governance power delegated to regional governments. Within budget constraints, regional governments have significant leeway in the design of the institutional arrangements whereby health care is managed: number and type of public health organizations (Local health authorities –LHA- and Independent hospitals), financing models, market share of private contracted providers and organization and service models. The regional government deliberates for each public and private provider the number of beds for each speciality, the kind and size of big technological instrumentation to be purchased by the provider and the total maximum annual budget allocated to each provider. The healthcare budget in the period of observation totalled ca. 18 billion euros per fiscal year.

The regional health care system of Lombardy has a reputation for being one of the best in the country (CERGAS, 2017). Lombardy is the region which attracts more patient mobility from other Italian regions. Since the mid of the 1990s the Lombardy region is the one with the highest market share of private contracted health care providers (28% of the total public health care budget), most of which

are large Italian for-profit health care groups. The system is based on a regulated competition between private contracted providers and public providers and patients are free to choose the provider they prefer with no restrictions.

Political and policy background: recent history before the reform

Since the establishment of a regional elective government, in 1970, Lombardy has been governed by a centrist or centre-right majority, with very few and short-lived exceptions (latest 1993-94). The dominant character in recent political history has been Roberto Formigoni, who performed as regional governor uninterruptedly for nearly 18 year from 1995 to 2013. He belonged to the political expression of a catholic movement, and governed in coalition with Berlusconi's party (named "Forza Italia") and the Northern League (a previously secessionist party later reshaped into an anti-immigrant, sovereigntist and populist party). He strongly operated to increase the market share of private providers from 10% of the regional health care budget up to 30% (CERGAS, 2017), by introducing the "purchaser-provider split" whereby Local Healthcare Authorities (LHA) acquired the role of purchasers of health services on behalf of patients and transforming all public hospitals in autonomous service providers, financed on a fee-for-service basis and in competition with private contracted providers, both for acute care, home care and LTC, which gained, respectively, the 30% of the health market share, 95% of the provision and 80% of the nursing home beds (CERGAS, 2017): private providers represent a key group of stakeholders. The slogan of the regional health care model was "patient choice freedom", meaning the possibility for patients of choosing the provider of health services. The model was embedded in a regional background with strong institutional capacity, a high level of medical competences and a good degree of social capital; even the pressure of the fiscal crisis, hitting hardly Italy and most Mediterranean countries in those years (for an overview of its perceived impact by public managers see Longo, 2016; Ongaro et al., 2015), was felt quite assuaged in the richest region of Italy.

The final stage of the Formigoni era was tainted by massive corruption scandals, with the Governor also personally hit, centred on the allegedly illegal benefits that people close to the government extracted from big private contractors. These scandals led to the forced resignation of Mr Formigoni and anticipated elections, which sets the stage for the episode of systemic change accounted for in this paper.

The emergence of a narrative for radical change and the role of policy indeterminacy

A new Governor, Roberto Maroni, was elected in 2013, from a different party (Northern League), but supported by the same political coalition. His governmental course of action was driven by the ambivalent imperative to both distinguish himself and mark his mandate as distinct from the Formigoni era, in order to leave behind the shadow of the previous scandals, but also guarantee a certain degree of political continuity, given a similar constellation of stakeholders was supporting his governing coalition. Given the political symbol *par excellence* of the Formigoni era was embodied by his health care model, the new governor undertook the design of a profound reform of the health care system, as a way of signalling discontinuity.

In formulating the argument for change, political discontinuity could only limitedly be evoked, because of the continuity of the supporting coalition, so the image of the policy issue was depicted in a scientific-technical way: he underpinned his argument on the epidemiological shift brought about by the aging society and the consequent arising centrality of chronic disease, which demands for a strong development of primary care and community services, a deep shift in focus from the previous model, very much centred on acute care hospitals and nursing homes.

The paradigm shift was significant and it took two years of internal negotiation and harsh infighting within the coalition before the reform championed by Maroni was passed, in summer 2015, met by strong resistances from the near totality of private hospital providers, a major stakeholder of the

governing coalition constituency. Other events imperilled the future of the reform: a few days after the reform bill had been enacted, both the regional minister for health care and Maroni's party health care expert and official advisor were arrested on charge of (another) corruption case, this time related to some public purchasing procedures and the outsourcing of public dentistry services. After a tense few months, a new regional minister for health care was appointed, but the situation remained troublesome: a new reform had been adopted on paper but not implemented, strong headwinds against it blew both from inside the governing coalition and from the contracted private healthcare providers; the inspirer of the new reform lay in jail, and the founding fathers of the previous model that had lasted nearly two decades were politically delegitimized due to the corruption scandal. The government was in a quandary: it was politically extremely challenging either to move forward with the new reform or to backtrack to the previous status quo, and the governor was already beyond mid-term, with only 24 month before the subsequent regional election campaign (due in March 2018). In these circumstances there was a political drive for radical change, in order to distance the political course from both older and more recent scandals. On the other side, the political ambiguities in the governing coalition hampered the consistency of the policy design. The combination of a need for radical change rhetoric, weak coalition and a short time span before the following elections led to a somewhat bold but very generic reform package, highly vague in its content, and additionally the same reform unfolded in four distinct acts, a regional law (law n. 23 of summer 2015) and three secondary legislation executive acts, the latter providing some details to the reform, the former representing but a broad framework to be filled. As a consequence, in our terminology, it may quite plainly be stated the reform was characterised by a high level of indeterminacy in policy design.

Outline of the design of the reform

According to the design of the reform of healthcare in Lombardy, community and hospital services were integrated into 27 comprehensive public health care organizations, and the purchasing organizations were merged into only 8 large commissioning authorities, with an average catchment

area of 1 mil inhabitants (with a separate arrangement for the three-million resident Milan area), assigning to it a role as local planner, regulator and controller of the system. The majority of the 105,000 civil servants employed in the regional health care system were relocated into the new 27 comprehensive health care organizations.

The new "mantra" was about integration, holistic approach to patients, case management in order to tackle the chronic condition challenge. In a highly symbolic move, the regional ministry for social care was merged to the ministry of health in order to establish a new integrated ministry for welfare, with the "chronic patient" – ultimately one every three residents – central in the rhetoric and the focus of political communication (the slogan was "*from providing care to taking care*"). Between January 2017 and August 2017, three significant planning documents were issued:

Regional Decree X/6164: Steering health care needs: implementing the chronic care model *(30/1/2017).*

Regional Decree X/6551*:* Providers network plan and case management for chronic patients *(4/5/2017)*

Regional Decree X/7038: Additional decisions to assess chronic care model providers *(3/8/2017)*

Jointly, they outlined the pillars of the new model. The first act was a systematic health population management exercise, clustering all patients in 65 different disease types, each one diversified along three levels of severity. The published data were aggregated and anonymous, while every public commissioning agency received the nominative list of its chronic patients, all classified in one of the 195 diseases cluster. For each of 195 different chronic conditions, a maximum number of treatments and health consumptions was set, correlated to a bundle-payment tariff.

The second planning document designed the governance architecture of the health care system, offering new potential roles both to public and private providers. Providers could put forward their

candidature to become ‘case-managing organisations’ and ‘commissioning organizations’ for chronic patient. Provider could also apply to be service producer for chronic treatments, under case management organizations’ commissioning. Providers could play simultaneously both parts in the comedy, for different patients. The new arenas were regulated by the local public planning and controlling agencies. A central part of the design lay in the strong push to GPs (which operated on an individual basis) to merge into cooperatives, which would take charge of case management and commissioning of chronic patients, with a pre-emption for all 1,9 mil low level patients. This act paved the way to a major public tender (in June and July 2017), run by each of the 8 planning and controlling agencies, offering to any public and private organization in the system to apply both for the case manager and the commissioner role, and the service provider role. The goal was to offer to every chronic patient a list of case managing and commissioning organizations to choose from, in order for patients to be supported by these organisations in the care of the diseases through all the spectrum of services: proactive medicine, annual treatment plan, administrative admission procedures run directly by the case manager, compliance control and support.

The third official act defined the required modalities and contractual forms and obligations that health care organizations had to adopt – reciprocally binding each other to the provider/purchaser role - in order to establish the integrated care networks able to take care of the entire gamut of the patient needs.

Patients would enjoy freedom of choice both with regard to their commissioning and with reference to the case management organization. Commissioning organisations select providers and sign binding agreements (legally they take the form of contracts); still, patients were free to opt out from the contracts, as they could more broadly opt out of the entire scheme. For the patient operating within the new chronic care model, all treatments would be reserved in back office by their case management organization, hence allegedly making access to services much easier and more comfortable.

The emphasis on patient free choice offered a good balance within the governing coalition to coalesce around a reform rhetoric combining continuity with the previous "Formigoni model" (pivoted around the "patient choice" slogan), on one hand, with a major, potentially disruptive, innovation which could anyway be claimed to be made necessary by "objective" epidemiological trends (tied to the aging society), on the other hand.

5. ENGAGING STAKEHOLDERS: HOW SYSTEMIC CHANGE UNFOLDED

A brand new game opened up for purveyors; whether each healthcare provider would have gained or lost in the new chronic care arena was an unknown, especially given the range of potential entrants in the new market of chronic care: any kind of healthcare organization could potentially put itself forward as case management and commissioning player, and also as service provider within the system. Public and private organizations were placed on a level playing field, with equal market access opportunities: Public providers, public teaching or research hospitals, cooperatives of GPs, private contracted hospitals or ambulatory providers, and nursing homes could all become case management and commissioning organizations.

The players of the new game were in the dark about what share of the market they would obtain in the end, and no robust forecasts were available given the radically different scenario where they had to operate. Citizens under chronic conditions received in January 2018 a letter from the local planning authority indicating a list of case management and commission organizations within the catchment area of the patient, and patients were free to step in and choose the case managing organization of their like, or to opt out of the model and maintain the previous arrangement. Even when a case management organization signed contracts for their patients, still patients retained the freedom to opt for any other provider of their choice. This high level of indeterminacy in the reconfiguration of the healthcare provision market and sheer uncertainty for each individual provider triggered a process

whereby actors were incentivised to opt into the system, in order to secure the chance to become a purveyor to the system at a later stage, should the market for chronic diseases, intermediated according to the new governance model, grow in the future. In a way, any player could project and attach to the new scheme either a major opportunity or a daunting threat. Uncertainty was not only related to the market share of each provider and between public and private organizations, but also between different health care settings. The competition between primary care professionals, acute care specialist and the large nursing home world (60,000 beds in Lombardy) was opened up, especially for the case managing and commissioning role, bringing more attention to the reform and participation by actors. In short, a combination of design feature (the very indeterminacy of the policy design) and market-type competition triggered by the funding regime (which basically set out one, comprehensive envelope of money for all the actors in the system) can be purported to have triggered the social mechanisms of *attribution of opportunity* and *attribution of threat* to the new circumstances by the stakeholders, leading to the entirety of the providers – public and private – to ultimately subscribe to the scheme.

Another event enabled to attract to the scheme two other sets of actors. Three major universities were jointly contracted as regional government advisors for securing the implementation phase and for showcasing the innovation at the local level. Each of the three universities had a solid reputation in health care management. They were also picked up as gatekeepers towards different categories of stakeholders. The Catholic University of Milan, placed mainly in Milan and Rome, has developed a robust tradition in health care management, both in teaching and research. Bocconi University is a major provider of both executive education and research in the healthcare sector and the hub of important networks of public and private health care top managers. The Polytechnic of Milan has a strong expertise in healthcare management and is very well established in the field of health care operations and ICT management. The universities advised jointly the regional government, shuttling local stakeholders' worries from the territory to the heads of the regional ministry of health in Milan.

They were in charge of communicating the reform locally. Each university addressed territorially different clusters of both public and private stakeholders, in each of the eight Local Healthcare Authorities at least ten meeting were held with different categories of stakeholders: GPs, private contractors, public hospitals, associations, and local governments. The three universities became key interlocutors in informing and 'explaining' to professionals the new governance model envisaged by the regional government: besides private acute hospitals and private ambulatory companies, also GPs, paediatrics, nursing homes were involved in systematic discussions of the proposed reform by the three teams of the universities – who acted in a very coordinated way due to previous personal acquaintances amongst themselves. Every group held discussions within peers and then with public policy makers, both at local and central level, building a cohesive web. The action of the three universities, by providing their reputation and legitimacy to the process and operating so diffusely on the territory addressing all the categories of stakeholders mentioned above, triggered the *mechanism of actor certification:* attesting the soundness and providing legitimacy to the new system of governance arrangement for chronic care management.

Beyond the involvement of the universities, opportunities for communications and listening were actively sought through a communication campaign targeted to various categories of stakeholders and at different territorial levels, through meeting and panels with the managers of all public organizations, the association of private health providers, the unions, and patients' associations at the central level. Each of the eight planning authorities had formal meetings with local public and private providers, with GPs, with the unions, with patients' associations and with local governments' representatives. Every Tuesday there was a meeting between all directors of the planning units and the director of the regional ministry of health and his staff. This communication campaign – a provision deployed along the course of the implementation process by the regional authorities – further reinforced acceptance of the new governance model by a range of stakeholders (it became a

design feature set up during the implementation phase that acted as a reinforcing factor in the change process).

Other stakeholders proved much more resistant to being swayed, though. The powerful private hospitals association was initially very sceptical, fearing that public health care budget would shift from acute, where it had a strong presence, to primary care, where they had initially poor market opportunities. Also, the influential medical society of Milan started a robust media campaign against the new chronic management model, which lasted several months. The main argument was that case management models, like the one proposed by the regional government, ultimately lead to economic interest to drive healthcare processes, to the detriment of the ultimate wellbeing of the patients. This strong intervention by the medical society of Milan resulted in a much lower percentage of GPs adhering to the new scheme in the Milan area. However, the percentage of adhesion was much higher in the rest of the Lombardy region, tallying an average of 48%, which may be deemed to be quite significant considering the average age of GPs in the region is 55 years, an age at which somebody is quite reluctant to change her/his way of working (in the hindsight, the weakness inherent in the system of territorial care, with too few GPs in charge of too many residents, operating in isolation and often approaching retirement age, proved to be detrimental to the capacity of the Lombardy health system to tackle the major shock of the COVID-19 crisis which broke out in winter/spring 2020 – though this is analytically unrelated to the process under observation in this contribution).

However, other key actors were fully won to the cause of adhering to the new scheme. While in May 2017 a board meeting of the paediatric union officialised opting out from the scheme, because of the wide uncertainty attached to it, the union then re-opened the option of opting in at a later stage. Notably, paediatrics were not used to work in cooperatives, and associating into cooperatives was a requirement for GPS (paediatrics are GPs in the Italian health care system, and each person aged fourteen or less has to register with a paediatric as the GP of reference). They turned to the universities

for advice, from which they drew two suggestions that affected their final choice: first, that the model is so open-ended and unpredictable in its impacts that it may powerfully be shaped by those who will first join it and the course of action they will concretely undertake; the balance of power between the professional groups in the health profession will also be widely affected by first movers. Second, the lack of experience with working in cooperatives is not an insurmountable hurdle, as a professional group can be hosted within the cooperative arrangements already set up by other GPs (so a paediatric could join of cooperative of GPs rather than have to set up her/his own with other paediatrics). Eventually, the consistency of the argument and the authoritativeness of the source of advice (three high reputed universities) won the argument, and the association of paediatrics totally reversed its initial opposition and opted to join the scheme. The experts from the three prominent universities provided legitimacy to the new scheme in the eyes of these professionals. The fact universities were interposed between the politicians (much less legitimate in the eyes of professionals, notably in the then scandal rife regional government) and professionals acted as means of decoupling mechanism empowering the legitimacy of the scheme in the eyes of this key stakeholder. The social mechanism of *actor certification* appears to have been at work providing a positive spin to the message beyond the low reputation of the initial sender of the message itself (the scandal-hit regional government). Also another social mechanism appear to have been in operation: the *mechanism of appropriation of mobilising structure*, whereby the universities acted as platform for mobilising professional groups, such as paediatrics, to join the reform (making them shift from the initial oppositional stance).

Another key actor was also won to the cause: private providers of acute services. In May 2017, the major opposition party organized a political conference on the reform. Rather than lashing out at the reform, the leading leftist party seemed to stress the positive side of the reform, notably its being focused on chronic diseases and the development of primary and ambulatory care service, a component of health services historically weak in Lombardy and a traditional battle horse of the left. However, party exponents did lash out to the overly constrained role for public providers in the new

designed scheme. The takeaway lesson for private providers was that they did need to enter this new 'market' in the time window before the subsequent elections (fast approaching in less than two years), otherwise in case of reversal of the political fortunes, the space for private providers in the new model would have shrunk (dramatically, in the viewpoint of this category of stakeholders), whilst the new governance model of chronic disease management was anyway destined to last, as it met also the favour of the main opposition party which was the only one realistic potential alternative party in government. The new model came to be framed by this set of stakeholders as both an opportunity and a threat: an opportunity for the expectation it would have lasted; a threat because under the scenario of the opposition party gaining power the space for private providers in the market would have dwindled: a void had to be filled promptly. Ultimately, all private providers of health services joined the reform deeming it more convenient to join the process, rather than being side-lined and hence inhibited to enjoy the prospective benefits if the outcome of the process turned out to be favourable: the *bandwagon effect* may explain the building up of sustained momentum for the new governance system to develop and institutionalise.

6. ANALYSIS AND DISCUSSION

The combination of design features - most notably, and our analytical focus, the very indeterminacy of the policy design, but also deliberate design provisions like the market-type competition triggered by the funding regime – and context factors (ranging from the reputation of local universities in the eyes of the clinical operators to the political stability of the regional government, whose majority had been there over two decades and in all likelihood would have been renewed at the subsequent electoral round, as it did happen, driving the expectations of all stakeholders towards adapting to the new system rather than betting on an unlikely policy change following up governmental turnover) led to the hypothesised activation of a number of social mechanisms, in certain concatenations, that has enabled, in the case observed, a systemic change in the governance of chronic care management, and,

complementarily, defused alternative courses of action that might have led to stall or dampen the reform.

It should be noticed that most of the triggers of the observed social mechanisms appear to have been non-deliberate, at least not deliberated in the design of the policy: indeed, we emphasise the indeterminacy of the policy design as one of the key enablers of the change process. More specifically, alongside the indeterminacy of the expected governance arrangements, it is the uncertainty about the expected impact – in terms of on the role and market share each provider of health services could expect to win out of the new governance arrangements for the management of chronic disease – which acted as enabler, due to it being accompanied by the triggering of other social mechanisms enabled by the multi-level communication and negotiation process and notably by the interposition of the three universities between policy-makers and the key stakeholders.

In itself, indeterminacy of policy design could have well triggered attribution of threat to the new circumstances, interpreted as a menace, hence stalling the change process. Instead, indeterminacy led to attribution of opportunity to be attached to the new circumstances. Central to the outcome was the multilevel communication and negotiation process towards stakeholders, run in a diversified and bespoke way, whereby some communication and negotiation channels operated on a collective basis as a function of the professional community involved (GPs, paediatrics) and some others on a local, decentralised basic, province by province. This way, there was enough room for some 'adaptive incoherence' in the messages offered by the different level of government to the diverse stakeholders. On top of this, crucial to the effective touting of the reform was the partial 'contracting out' of stakeholder management to three major regional universities. The universities offered a sort of open discussion space, where the prestige of the researchers and the formal absences of the official policymaker offered a setting for direct observation and comments, which supported a better understanding of stakeholders' expectations. Universities acted as mobilising structures. It worked

also as a robust sense-making process able to explain the vision of the reform, without the need to immediately come to political negotiations.

The mechanisms that we empirically conjectured to be at work in a combined way include: the *mechanism of actor certification* by interposing authoritative institutions between (the partly discredited in the eyes of stakeholders) policy-makers and the key stakeholders for the change process to gain traction; the *appropriation of mobilising structure* mechanism for decoupling and recoupling of communication and negotiation channels, by means of the multiple channel of communication occurring at both local and central level, in such a way that *attribution of opportunity* by key groups of stakeholders shaped the dominant stance - defusing the initial stance characterised by the potential *attribution of threat* to the new circumstances opened up by the reform and its indeterminacy; and finally, the *band-wagon effect* mechanism based on rational imitation, whereby successive actors opted for joining the chronic care management scheme and opted in, sustained the change process and enabled to build momentum to the change process and reinforce a self-sustaining dynamic.

Ultimately, the combined activation of these mechanisms performed as enabler of substantial systemic change, as measured both in terms of the number of players which signed into the model (the entirety of private providers as well as of the professional groups), and the overall shift in focus of the health care agenda from acute to chronic disease management. This specific concatenation of social mechanisms may provide an explanation about why system-level change occurred in the way recounted here.

7. CONCLUSIONS

We propose the approach of the analysis of social mechanisms as a conceptual tool to explain systemic change in public governance and public services management, and we undertake to develop

such approach by applying it to the case of systemic change in chronic disease management in the Italian region of Lombardy. Specifically, our analysis sheds light on system-level change under conditions of policy indeterminacy, and our core argument is that certain concatenations of social mechanisms, like the ones highlighted in the case study of chronic disease governance in the Italian region of Lombardy, may enable to explain systemic change, and why it occurred under otherwise unfavourable conditions.

In particular, we claim that policy indeterminacy may be an enabler of systemic change – contrarily to what might be expected – and we provide an analytical explanation for how this unexpected course of events may occur. Hence, the analysis of social mechanisms provides a valuable repertoire of conceptual tools for explaining the occurrence of courses of action which would have been highly unlikely to happen otherwise: notably, major, systemic change is generally assumed to be hard to put into effect, and absence of policy clarity is generally seen as recipe for stalled or aborted, rather than implemented, change to occur. In terms of the generalisability of the findings, we would consider most public policies to be generally characterised by 'determinacy' of the policy design, and even more so in sectors where technical knowledge and expertise is a key factor as is the case of the healthcare sector. And yet there are instances in which the level of indeterminacy is so relevant to enable classifying it as "high" on policy indeterminacy: this condition may open us a set of process dynamics which differ from the (more common) circumstances under which this is not the case. This study aims to shed light on what happens under these circumstances, and its findings might enable a better understanding of how system-level change in welfare systems may unfold, under conditions similar to the ones we have outlined.

More broadly, we argue that the analysis of social mechanisms may be a powerful approach for generating knowledge about effective change management in public governance and public management. The analysis of social mechanisms is an approach which may usefully complement

other approaches to change management in this field. In this perspective, we join the call for other scholars in the field of public governance, policy and management (Asquer, 2012; Barzelay, 2003; Barzelay and Gallego, 2006 and 2010: Capano et al., 2019; Mele, 2010; Mele and Ongaro, 2014; Ongaro, 2006, 2013a and 2019) for the renewed significance of the analysis of social mechanisms for the study of institutional, policy and administrative change.

References

Asquer, Alberto 2012. Managing the Process of Decentralization: Transforming Old Public Entities into New Agencies in the Agricultural Sector. *International Public Management Journal* 15(2): 207-229.

Barzelay, M. (2003), "Introduction: the Process Dynamics of Public Management Policymaking", *International Public Management Journal*, Vol. 6, N. 3, pp. 251-282.

Barzelay, M. and Campbell, C. (2003) *Preparing for the Future: Strategic Management in Government*. Washington, DC: The Brookings Institutions.

Barzelay, M. and Gallego, R. (2006) From 'New Institutionalism' to 'Institutional Processualism': Advancing Knowledge about Public Management Policy Change. *Governance*, 19(4), pp. 531–57.

Barzelay, M. and Gallego, R. (2010) The Comparative Historical Analysis of Public Management Policy Cycles in France, Italy, and Spain: Symposium Introduction. *Governance*, 23(2), pp. 209–23.

Bates, D. W., Saria, S., Ohno-Machado, L., Shah, A., & Escobar, G. (2014). Big data in health care: using analytics to identify and manage high-risk and high-cost patients. *Health Affairs*, 33(7), 1123-1131

Boudon, Robert (1991) "What Middle-range Theories are", *Contemporary Sociology*, Vol. 20, N. 4, pp. 519-522.

Capano, Giliberto, Howlett, Michael, M. Ramesh and Altaf Virani (eds.) (2019) *Making Policies Work: First and Second Order Mechanisms in Policy Design*. Cheltenham, UK and Northampton, MA: Edward Elgar.

Capano, Giliberto, Howlett, Michael and M. Ramesh (guest editors) (forthcoming) 'A Mechanismic Approach to Public Policy: Improving Policy Design by Better Understanding Policy Mechanisms', Special Issue in *Public Policy and Administration*

CERGAS (2017) *Rapporto OASI*, Milan: Egea.

Eisenhardt, Kathleen M. (1989) 'Building theories from case study research', *Academy of Management Review*, 14:4, 532-50.

Elster J. (1989) *Nuts and Bolts for the Social Sciences*. Cambridge: Cambridge University Press.

Elster, J. (1993) *Political Psychology*. Cambridge: Cambridge University Press.

Elster J. (1998), “A Plea for Mechanisms”. In P. Hedstrom and R. Swedberg, eds. (1998), *Social Mechanisms: an Analytical Approach to Social Theory*. Cambridge: Cambridge University Press, 45-73.

Gambetta, Diego (1998), “Concatenations of mechanisms”. In P. Hedstrom and R. Swedberg, eds. (1998), *Social mechanisms: an analytical approach to social theory*. Cambridge: Cambridge University Press, 102-124.

Hedstrom, Peter (2005), *Dissecting the social*: *On the principles of analytical sociology*. Cambridge: Cambridge University Press

Hedstrom Peter and Richard Swedberg, eds. (1998), *Social mechanisms: an Analytical Approach to Social Theory*. Cambridge: Cambridge University Press.

Longo, F., (2016) Lessons from the Italian NHS retrenchment policy, *Health Policy*, Volume 120 , Issue 3 , 306 - 315

Mele, Valentina 2010. Government Innovation Policy in Italy (1993-2002). Understanding the Invention and Persistence of a Public Management Reform. *Governance* 23(2): 251-276.

Mele, Valentina and Edoardo Ongaro (2014) “Public Sector Reform in a Context of Political Instability: Italy 1992-2007”, *International Public Management Journal*, 17:1, pp. 111-142.

Melloni, Erica, Flavia Pesce and Cristina Vasilescu (2016) ‘Are Social Mechanisms Usable and Useful in Evaluation Research?’, *Evaluation*, 22:2, 209-227.

Nolte, E., Knai, C., & Saltman, R. B. (2014). Assessing chronic disease management in European health systems. *European Observatory on Health Systems and Policies*.

Ongaro, Edoardo (2006) "The dynamics of devolution processes in legalistic countries: Organisational change in the Italian public sector", *Public Administration*, 2006, 84:3, 737-770

Ongaro, Edoardo (2013a) "The administrative reform trajectory of the European Commission in comparative perspective: Historical New Institutionalism in compound systems", *Public Policy and Administration*, 28:4, pp. 346–363.

Ongaro, Edoardo (2013b) "Explaining contextual influences on the dynamics of public management reforms: Reflections on some ways forward" pp.192-207 in Christopher Pollitt (ed.) (2013) *Context in public policy and management: The missing link?*, Cheltenham, UK and Northampton, MA: Edward Elgar.

Ongaro, Edoardo (2017) *Philosophy and Public Administration: An Introduction*. Cheltenham, UK and Northampton, MA: Elgar

Ongaro, Edoardo (2019) 'Advancing the Theory and Practice of Public Sector Reform through the Analysis of Social Mechanisms' in Giliberto Capano, Michael Howlett, M. Ramesh and Altaf Virani (eds.) *Making Policies Work: First and Second Order Mechanisms in Policy Design*. Cheltenham, UK and Northampton, MA: Edward Elgar.

Ongaro, Edoardo, Ferré, Francesca and Giovanni Fattore (2015) "The Fiscal Crisis in the Health Sector: Patterns of Cutback Management across Europe", *Health Policy*, 119:954-963.

Pettigrew, Andrew M. (1990) 'Longitudinal field research on change: Theory and Practice', *Organization Science*, 1.3, 267-292.

Pollitt, Christopher (ed.) (2013) *Context in Public Policy and Management: The Missing Link?*, Cheltenham, UK and Northampton, MA: Edward Elgar.

Stinchcombe, A (1991) "The Conditions of Fruitfulness of Theorizing about Mechanisms in Social Science", *Philosophy of the Social Sciences*, 21(3), pp. 367-88.

Van de Ven, Andrew H. and Marshall Scott Poole (1990) 'Explaining development and change in organizations', *Academy of Management Review*, 20, 510-540.

Yin, Robert K. (5th edition 2018) *Case Study research and Applications: Design and Methods*. London: Sage.

Wyke, A. (2011). 'The future of healthcare in Europe. A report from the Economist Intelligence Unit', *The Economist, 35-48*