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David Vallat, Sandra Bertezene

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HYPERCONTROL AND HYPERNORMALISATION OF THE HEALTH SYSTEM: PROPOSAL FOR A SYSTEM OF SHARED CONTROL

David VALLAT
Sandra BERTEZENE

Abstract: The control system for health services suffers from a superposition of external assessments and controls produced by hypernormalisation which makes it difficult to organise an effective internal control system that would allow all concerned to make truly informed decisions. The aim of the model proposed in this article is to counteract the perverse effects of such normalisation. The model offers a system of shared, systemic control comprising three interdependent dimensions: efficiency (objectivity), effectiveness (subjectivity) and ethics (intersubjectivity).

INTRODUCTION

The need to define and introduce an organisational control system in the health sector in France became apparent in the 1990s, with the implementation of various major reforms of the ‘New Public Management’ type. An IGAS report nevertheless reported “insufficient articulation between the control-type inspection function currently exercised by the local authority networks and the other procedures intended to improve the quality and security of the care provided in the establishments” (Schaetzel & Tregoat, 2013, p.3). Control-type inspection function missions have objectives that are independent of each other (quality inspection, negotiation at the time of contractualisation, etc), and compartmentalised between the health sector and the social and medico-social sector. The IGAS report refers to a “superposition of procedures with no strategic vision and no legibility” (Schaetzel & Tregoat, 2013, p.25) either at the level of the supervisory authority or at that of the establishments and services themselves.

Despite the existence of abundant literature on the subject of the coordination of the different types of control within a single system (see more particularly Merchant & Van der Stede, 2007; Malmi & Brown, 2008), little work has been carried out on the way in which these different types of control could be coordinated or combined within a single system (Malmi & Brown, 2008). Working on this topic is therefore of academic interest, to which is added another, more professional, interest connected with the field of research. This specific context gives rise to one central question: what system of organisational control could be implemented within health, social and medico-social organisations in such a way as to prevent the superposition of procedures (assessments and inspection-type controls) and inform decision-making (on strategy, organisation and operation)? The proposal put forward here in response to this question is that the various internal assessments and procedures that underpin control could interact within a single system on condition that a systemic vision of the organisation is adopted, coordinating three interdependent dimensions: effectiveness, efficiency, and ethic.

In an attempt to answer the question and support the proposal put forward, this article presents, in its first section, the specific context of organisational control within health, social and medico-social organisations; the second section presents the theoretical and epistemological framework of the proposed model, while the final section presents our model of a system for organisational control that is concomitantly objective, subjective and intersubjective.

1. ORGANISATIONAL CONTROL OF HEALTH, SOCIAL AND MEDICO-SOCIAL ORGANISATIONS

Assessment processes within health, social and medico-social organisations raise two problems: firstly, they abound because of hypernormalisation but do not present any strategic vision of the control (1.1); secondly, they suffer from the confusion maintained by the supervisory authority regarding the aims of the assessments (1.2). In addition to these initial difficulties there are those connected with the culture of a sector that does not particularly welcome control (1.3), and those connected with the environment of the organisations, which has become more unsettled and uncertain, such that the very characteristics of normalisation and control do not appear to be particularly appropriate (1.4).

1.1. Juxtaposition of the assessments required by the regulations

The strategy of the organisations concerned is assessed (at least partially) by the supervisory authority in the context of multi-year contracts of aims and means. This contractualisation procedure exists for health establishments (Act of 24 June 2009 [*French legislation*]) and for social and medico-social establishments (Act of 2 January 2002 [*French legislation*]). A contract is concluded between an establishment (or a service) and a pricing authority for a period not exceeding five years. The organisation undertakes, during this period, to achieve objectives in terms of the development of services or activities, improvement in quality, etc. In return, it receives a budget allocation from the pricing authority. Issue no. 2014/9 of 15 October 2014 of the official newsletter entitled ‘Santé – Protection Sociale – Solidarité’ [*health, social protection, solidarity*] offers a guide to objectives and indicators for guiding these multi-year contracts. The guide comprises “common national priority and operational objectives and levers for action identified as being useful in achieving the objectives; a regional range of objectives specific to each regional health agency (Agence Régionale de Santé - ARS), allowing coordination of the regional priorities thrown up by the regional health plan (Plan Régional de Santé - PRS) with national priorities, in the context of objective-driven implementation; common indicators selected on the basis of the national priorities, with target figures at the national level and regional targets differentiated according to local contexts and efforts that have already been made” (‘Santé – Protection Sociale – Solidarité’ newsletter no. 2014/9, 2014, p.1).

Quality is also the subject of regular assessments by the supervisory authority. In the hospital sector, ordinances promulgated on 24 April 1996 made certification compulsory for public and private hospitals, independent plastic surgery units, and health cooperation groupings. In its Decision No. 2013.0142/DC/SCES of 27 November 2013, the college of the French health authority (Haute Autorité en Santé - HAS) states that “the purpose of certification is to assess the quality and safety of treatment dispensed and all the services delivered by the health establishments and other structures subject to the present procedure. More particularly, it takes account of their internal organisation and patient satisfaction”. Article L.710-5 of the [French] Public Health Code stated that this assessment is carried out using “indicators, criteria and reference frameworks covering the procedures, good clinical practices and results of the various services and activities of the establishment”. This external quality assessment is carried out every four to six years by independent specialist inspectors under instruction from the HAS. They compile a report which, if positive, allows the establishment to be certified. The certification process therefore requires the implementation of a continuous quality improvement process in order to ensure that practices comply with the requirement of the reference framework. The same applies within social and medico-social services and establishments since the Act of 2 January 2002 [*French legislation*] made continuous

improvement procedures compulsory with a view to internal and external quality assessments. External assessments are carried out by independent auditors accredited for the purpose; as for hospital certification, they draw up a report that is sent to the HAS (the HAS has since absorbed the national agency for assessment and quality of social and medico-social establishments (Agence Nationale de l'Evaluation et de la Qualité des Etablissements et Services Sociaux et Medico-Sociaux - ANESM).

The objectives laid down in the context of these multi-year contracts of aims and means and quality procedures are supposed to be included in the establishment's project that formalises strategy over a five-year period, but which may be revised before expiry if the establishment deems this appropriate. The establishment's project defines the "objectives, particularly with regard to the coordination, cooperation and assessment of its activities and the quality of not only its services but also its organisational and functional methods" (Article L.311-8 of the [French] Code of Social and Family Affairs). The establishment's project also lays down the means the establishment ought to have at its disposal in order to achieve its objectives. The same applies in the health sector, for which Article L.6143-2 of the [French] Public Health Code indicates that the establishment's project defines its general objectives in the medical field and with regard to nursing care, biomedical research, social policy, training plans, management, and the information system it uses.

1.2. Superposition of voluntary assessment procedures

As the IGAS report points out, the procedures for drawing up an establishment's project, providing input to a multi-year contract of aims and means, and carrying out a quality procedure are carried out independently from each other, whereas - given their common objectives - they ought to be coordinated.

In addition to these major procedures there is also a number of other compulsory internal procedures with a view to carrying out the external 'controls' or 'inspections' specific to each sector of activity. In the health sector, for example, a radiotherapy unit may be inspected not only by "structures with the power of administrative inspection [...] but also by other institutions such as health insurance bodies [...], specialist inspectors for the HAS, etc, with no systematic coordination among these administrative policing bodies, possibly leading to a degree of confusion regarding their roles" (Schaezel & Tregoeat, 2013, p.26). The same applies within social and medico-social establishments and services which are, for example, subjected to control-type inspections carried out in the context of the national control guidelines for combating abuse.

Alongside these statutory provisions, the national agency for supporting performance (Agence Nationale d'Appui à la Performance - ANAP) in health and medico-social establishments proposes dashboards for use by administrators of health, social and medico-social organisations. Deployment of these tools currently constitutes the only assistance these administrators have for their guidance work. The ANAP proposes a performance dashboard adapted to the medico-social sector comprising indicators divided into four groups: providing treatment for patients and accompanying them, human and material resources, financing and budget, and objectives. The dashboard is kept up to date on-line by the executive management of the establishment or service, which has access not only to its own data but also to the aggregate of data for a group of organisations in the same category. The data may be accessed by the supervisory authority not only in order to foster the guidance of a particular offer, but also to promote discussion among the organisations, the ARS and the general council. The ANAP has also developed a dashboard for steering the performance of health establishments of the medico-surgical-obstetric type which makes it possible to compare the establishments and obtain themed views by group of establishments, by region, or at the national level according to five themes covering 68 indicators: activity, quality of practices, organisational

performance, use of human resources, and finances.

The substantial constraints imposed by the regulations and the proposals from the ANAP do not prevent health organisations also developing projects that respond to their own ambitions. These projects are not specific to the health, dependency and handicap sector; they may, for example, cover ISO-type certification procedures, sustainable development policies, etc. These various procedures call for close guidance and therefore constitute an additional quantity of assessments and indicators to be reported within the organisation; in some cases they are not intended for transmission to the supervisory authority but to third-party bodies with a view to obtaining a label or certification.

The redundancy of this work and its time-consuming nature (Schaetzel & Tregoeat, 2013, p.26) ought, in theory, to encourage administrators to coordinate the various assessments, with an eye to sensible organisational control and ease of guidance within the organisation.

Apart from the existence of a plethora of assessment procedures and indicators as already explained in this section (see Table 1), it is necessary to take another difficulty into consideration: the culture of the sector, which is far removed from the principles of assessment and control.

Table 1

Main dysfunctions in the external control of health, social and medico-social establishments

Dysfunctions	Examples
<p>Plethora and superposition of external controls (and therefore indicators) with no strategic vision or legibility at the level of either the supervisory authorities or the establishments and services.</p> <p>Lack of coordination between the objectives of the external control of quality, the other objectives of control-type inspections and contractualisation (achievement of strategic objectives in exchange for the allocation of resources).</p> <p>Lack of coordination of external control of quality (carried out nationally) in health, social and medico-social services and establishments, the other inspections and controls (carried out locally), and the contractualisation of these establishments with the supervisory authority (strategy and allocation of resources).</p> <p>Difficulty for the regional health authorities (<i>Agences Régionales de Santé</i> - ARS) in accessing the data produced by the various external controls and control-type inspections because of internal compartmentalisation.</p> <p>Lack of harmonisation of practices of the various ARS in terms of external control.</p> <p>Failure to take account of the indicators produced by the establishments to obtain labels or ISO-type certifications (regarding quality, sustainable development, etc).</p>	<p>The quality indicators supplied by services and establishments differ. Some refer to the implementation of the multi-year contract of aims and means and are intended for use by the ARS (regional level), while others cover the external control of quality and are intended for use by the HAS (national level).</p> <p>Procedures that involve supporting a multi-year contract of aims and means and carrying out a quality procedure are carried out independently of each other and not simultaneously, whereas they ought to be simultaneous and coordinated, since they pursue the same aims.</p> <p>The results of previous inspections are almost never used, whereas they could enrich the choice of priorities in the multi-year contract of aims and means.</p>

Based on Bertezene (2018)

1.3. Tension among the values being upheld

The culture of the sector upholds “humanist values that reflect [...] respect for the dignity of every person, non-discrimination, and equality of treatment due to all” (Molinié, 2005, p.42). This culture upholds the feeling of working for “the common good” (Nonaka & Zhu, 2012) and it is primarily for this reason that the ‘clan’ of health professionals tends to oppose organisational values expressed in administrative terms and the use of tools supported by the techno-structure. Budget pressure reinforces the phenomenon by giving rise to resistance and sometimes to data manipulation (Georgescu & Naro, 2012). On the one hand, management

tools often seem rigid and restrictive, their objectives are not always understood, and their appropriation often involves individual strategies on the part of the players concerned. On the other hand, the very nature of the tools deployed leads the players to feel their activity is no longer directed towards “the common good” but rather towards a “managerial logic”, perceived as being lacking in humanism and often of no use at all. For example, hospital staff report that the certification procedure pays little regard to difficult working conditions; reporting requirements result in discouragement and sometimes even a feeling of uselessness, particularly since there is sometimes also a feeling of lack of progress in the quality and safety of the treatment being provided (French Court of Auditors, 2012; HAS, 2012). The tarnished image of assessments and controls was such a sensitive issue that the ANESM published an opinion aimed at clarifying the objectives of the indicators introduced in the context of quality assessment. The opinion refers to this reticence on the part of professionals to use the indicators and states that “while it is important to hear this resistance, [...], the indicators are still relevant in supporting the internal assessment procedure [...]” (ANESM, 2015, p.1). Despite the efforts of the supervisory authority to spread a culture of control, amalgams and confusions still persist regarding the very nature of the assessments and control-type inspections.

Within the organisations, the term ‘assessment’ is preferred to that of ‘control’, which the professionals view with greater suspicion. ‘Control’ is indeed often seen as a kind of reporting for use by the supervisory authority (or by a head office) with more view to sanctions than to rewards. An illustration of this is the case of an establishment which had its operational authorisation withdrawn following a control mission, whereas the authorisation had just been renewed further to the good results reported in an external assessment (Schaetzel & Tregoat, 2013, p.26). We may also note on this point that the coordination of external quality control and operational authorisation was challenged by another IGAS report recently (Hesse & Leconte, 2017). The term ‘control’ is therefore often assimilated to the ‘control-type inspection’ function of the supervisory authority and its coercive vocation. This amalgam is also a result of the fact that “the various ARS may feel that certification and inspection are partially substitutable because they fail to understand the difference between the peer judgment that is specific to certification and the administrative policing that is the hard core of inspection. [This confusion is also maintained when] the various ARS consider that assessment reports, particularly external reports, could be used in support of a mission of control-type inspection [...]” (Schaetzel & Tregoat, 2013, p.3).

As the following point will show, these difficulties appear to stand in the way of the adaptation to the uncertain environment in which most of the organisations exist that has now become essential.

1.4. Health, social and medico-social establishments and services in a VUCA environment

As just explained, the health services environment is highly standardized. More precisely, we can say that it is hyper-tetranormalized. Tetranormalization (Savall and Zardet 2013, Boje 2015, Cappelletti et al., 2015) is a concept that refers to the issues and questions posed to companies and organizations by the increasing standardization around the world. These standards can be classified into four categories: accounting and financial standards; social standards; quality, safety and environmental standards; commercial and technical standards. Hyper-tetranormalization has different negative effects in the healthcare sector: inconsistent juxtaposition and superposition of regulatory and voluntary assessments, tensions in institutions, etc.

In addition, health services evolve in a volatile, uncertain, complex and ambiguous environment (VUCA), which seems more and more incompatible with hyper

tetranormalization. Indeed, being in a VUCA (Johansen, 2007) environment means needing to be able to cope with four challenges:

- Volatility, because it is difficult to anticipate the effects of the changes that are occurring (Boston Consulting Group, 2012). For example, the clear domination of associations in the handicap field could be challenged by the economic crisis and the shortage of resources in general. This is also the case where groups of private health and medico-social establishments become concentrated, or when there are developments in e-health and other phenomena which alter the economic, social, technological, etc aspects of the health sector;
- Uncertainty, since it is impossible to have control over all the parameters of the environment and even more difficult to anticipate changes. Uncertainty delays decision-making. It is no longer possible to rely on past experience in order to anticipate the future (Taleb, 2010) and this is the case, for example, of public financing, which has ceased to be a given. Understanding this uncertainty therefore becomes a major challenge in the organisations' strategy (McCann, 2009);
- Complexity is exacerbated by the systemic dimension of the environment. It is very difficult to grasp the interactions of all the component parts (lifestyles, pollution, ageing of the population, economic crisis, mega-mergers of pharma companies, the arrival of NBICs (nanotechnology, biotechnologies, information technology and cognitive sciences), the arrival of Generation Z on the labour market, the wide-scale use of the social media, the growing demands of patients and their families, new regulations, greater demands for sustainable development including with regard to health, etc). This complexity amplifies uncertainty and challenges the western (positivist) conception of the formation of knowledge (Morin, 1986; Morin & Le Moigne, 1999);
- Ambiguity, since it is difficult to interpret clearly the phenomena being observed. This leaves the way open to errors of interpretation (Taleb, 2010), as was the case during the 2003 heatwave and the 2009 avian flu epidemic.

Having described the field of study, its demands and limits in terms of organisational control, the following section will indicate the contours of the theoretical framework of the model proposed in order to reach beyond the limits studied.

2. THEORETICAL AND EPISTEMOLOGICAL FRAMING OF THE MODEL: SHARED CONTROL AND CONSTRUCTIVISM

The theoretical framework of the model is based on Simons' control levers (1990, 1995) in order to reach beyond the limits of a blurred control system in a sector in which the culture is not particularly favourable to the very idea of control (2.1). This first point leads us to adopt a constructivist, systemic approach to control in order to reconcile the vertical external control imposed by the supervisory authority with the internal control that fosters autonomy and horizontal coordination, this second type of control system being more suitable to the new ways work is being organised, in keeping with the VUCA environment of the health organisations (2.2).

2.1. Interactive control of health, social and medico-social organisations

Simons (1990, 1995) identified four control levers (see Table 2): beliefs systems, boundary systems (systems making it possible to frame strategy), diagnostic control systems, and interactive control systems (systems making it possible to define, stimulate and implement strategy).

Firstly, control-type inspections fall within the logic of the boundary system since they oblige administrators to concentrate on the risks to be avoided. Secondly, the assessments imposed by the supervisory authority mainly fall within the diagnostic control system, a classic form of

control that favours subordination and makes it possible to compare results with either objectives and norms or the results of actions to bring about improvements through change. Thirdly, boundary and diagnostic system controls are implemented independently of any form of beliefs system. As already explained, the players have the feeling that the control as implemented does not complement the treatment activity and indeed is out of sync with it, thereby flouting the humanist values upheld by the health organisations.

Conversely, on the one hand the interactive control system stimulates the active participation of all concerned, and encourages the exploration of new knowledge and the emergence of strategies, while on the other hand the beliefs system is based on explicit, clear values that are transmitted to all concerned (regardless of hierarchical level and activity: medical, paramedical, technical, administrative, etc), and makes it possible to develop a culture, a strategy (formalised in the establishment's project and the multi-annual contract of aims and means), and organisational objectives (plans for services) that stimulate meaningfulness, including for those people involved in the reporting and control activities. In fact, the interactive control system and the beliefs system promote the adoption of complex thinking and consider management control as a constructivist tool for organisational learning.

Table 2
Control systems in the health sector

	Restrictive control systems mobilising different forms of control	Stimulating control systems directed towards organisational learning
Control systems making it possible to frame strategy	Boundary System <i>(control-type inspection)</i>	Beliefs System
Control systems making it possible to stimulate strategy	Diagnostic System <i>(multi-annual contract of aims and means), establishment's project, quality certification and assessment, etc)</i>	Interactive System

Based on Simons (1995)

Indeed, contrary to diagnostic control, the interactive control defined by Simons (1995, 2000) aims to not only facilitate the implementation of strategy but also define and support it in a logic of knowledge management and organisational learning. In this way, control becomes a formal process based on information that enables the administrator to maintain or modify certain configurations of the organisation's activities (Simons 1991, p.49).

Combined with a beliefs system that is clearly centred on humanist values (aimed at staff as much as at patients and those close to them), interactive control adds a new dimension to control by coordinating it with strategy through the implementation of different principles (Bisbe et al., 2007): the use of interactive control by executive and operational management, the introduction of discussions, the development of an attitude favourable to discussion and the emergence of innovations, and lastly substantial attention being paid to uncertainties. Thus interactive control is used not only by the executive management in its strategic decision-making but also by administrators in their organisational decision-making (Renaud, 2013). Although Simons does not defend this clearly, it is possible to consider that interactive control may also be of use in operational decision-making by members of staff with no hierarchical responsibilities. Like Mintzberg (1989), we posit the hypothesis that giving responsibility in this way to all in the definition and implementation of strategy promotes collective involvement and commitment and hence performance.

The introduction of a principle of regular discussions that are frequent enough to allow debate and dialogue encourages managers to take an interest in strategic threats and opportunities, which in turn stimulates innovation. Within health, social and medico-social organisations,

innovation may be technological, medical or paramedical, but more often than not it is organisational and takes the form of various changes (change in the organisation of work, training schemes, etc, in order to improve treatment or reduce the health and safety risks staff face, etc).

This interactive control is based on the empowerment and involvement of the various hierarchical levels with a view to producing innovation in an ascendant process but without excluding the possibility of a range of strategic decisions by using a descending process in the long term (in the establishment's project or multi-annual contract of aims and means, for example), the medium term (in organisational objectives) and the short term (specific operational actions).

Interactivity arises out of discussion among the different hierarchical levels (for example, among the person in charge of the treatment, health administrators, nurses and nursing assistants), and among the managers of different services or activities gathered together for a common project. This interaction is the source of all organisational learning (Argyris, 1993) and all production of knowledge (Nonaka, 1994); it therefore allows a better grasp of strategic uncertainties (Dambrin & Löning, 2008) thanks to a system designed as a "catalyst for debate, permanent questioning of hypotheses and action plans" (Simons, 1995, p.97).

2.2. The epistemological framework of the model: system and constructivism

The model proposed takes form and comes alive when a systemic, constructivist approach to the control system is adopted.

2.2.1. A systemic perspective of the organisation and its control system

Action within and on a VUCA and hyper tetranormalised environment in a sector that aims to uphold humanist values calls for complex thought. The action project is drawn up using uncertain resources in order to achieve objectives that are also subject to the constant interplay of action, reaction and retroaction. The systemic (or complex) approach attempts to link the interactions and make them visible; it is multidimensional, transdisciplinary and dialogical¹, like observed reality (Morin, 1986). We live in a chaos of the actions, interactions, retroactions, and random events that constitute our phenomenal world. The aim of knowledge is to help us make sense of the chaos (to then be able to take action), but by sorting, hierarchising, eliminating and assembling to excess we lose sight of the nature of observed reality. Thinking in conjunction with complexity means thinking of observed reality as a fabric (from *complexus*: that which is woven together) composed of heterogeneous elements that are intrinsically connected. Complexity is both more and less than the sum of its parts (in the same way as fabric is both more and less than the sum of its threads woven together). On the one hand, a mosaic is much more than the sum of its constituent tesserae (a heap of tesserae does not constitute a mosaic), while on the other hand we can only see one side of each tessera in a mosaic). Conceiving simultaneously of one unit in a multitude and the multitude in one unit goes against our disjunctive habits of mind.

A complex vision of the environment makes it possible to grasp the systemic dimension (Le Moigne, 2007) of observed reality while at the same time reintroducing the subject which, in western (positivist) science, has been eliminated (since by eliminating the subject we eliminate complexity; Morin & Le Moigne, 1999). Grasping complexity consists of concentrating on the various underlying principles (Morin, 2005, p.98 *sq.*):

- the dialogic principle consists of reaching beyond the contradiction of the conjunction of contraries;

¹ "The dialogic principle may be defined as the complex (complementary/concurrent/antagonistic) association of instances that are *necessary together* for the existence, functioning and development of an organised phenomenon." (Morin, 1986, p.98; author's italics).

- the recursion principle means that the products produce the causes that produce the products in endless feedback loops, thereby breaking with the principle of cause and effect; this is a principle to be found, for example, in organisations that practice agile management (which encourages collaboration and the disappearance of hierarchies) (Schwaber & Beedle, 2001; Houle et al, 2015);
- the hologram principle considers that the whole is in the part and the part is in the whole, such that there is ontological interdependence. Looking at a hologram involves looking at a whole (an image) that is made up of single points, each of which retains the memory of the complete image.

This epistemological approach appears to be particularly suited to the field being studied, given its complexity. Given the deterioration of energy (entropy), an organisation's strength lies in creating negentropy. The prime illustration of this is provided by those living systems which are able to adapt and evolve because they are open (Morin, 2005). This is indeed the case of health services and establishments which are subject to the multiple influences (political, economic, social, technological, regulatory) that create this complexity, which in turn influences the creation and functioning of management control (Abernethy et al., 2007).

By adopting a systemic approach, the managers of establishments or services are able to view their decisions as the result of a system that influences its environment, which in turn influences the system comprising interactions connected to feedback loops (auto-eco-re-organisation)².

Now that the foundations of the systemic approach have been laid down and explained, we shall go on to add the foundations for constructivism in the following point.

2.2.2. Constructivist organisational control

According to constructivist epistemology (von Glasersfeld, 2007; Le Moigne, 2007), knowledge is the fruit of a construction, i.e. of subjective interactions between the humans and the objects being studied. These social interactions (Bandura, 1976; Tsoukas, 1996) may of course arise in the workplace (Brown & Duguid, 1998) in the context of management control, thereby allowing the organisation to constantly (re)construct knowledge. Learning is then thought of as a process aimed at compiling operational knowledge ("actionable knowledge" to use the term coined by Chris Argyris; Argyris et al., 1985) that matches a specific context such as that of a hospital or a medico-social establishment.

Constructivism is particularly suited to a VUCA and hyper tetranormalised environment since it reinforces the idea of gradual learning based on the interactions of social relationships. It is also at the core of the control defined by Simons (1995), as demonstrated by Dambrin and Löning (2007), who distinguish four constructivist themes in Simons' theory: control tools as a language for representing reality, the interactivity of control systems as a source of the development of knowledge, the link between strategy and control that makes theory inseparable from action, and lastly the incorporation of uncertainty (in a VUCA and hyper tetranormalised environment) in control systems.

On the basis of these theoretical and epistemological foundations, the following section describes the model of a 3E shared control system (the three Es being efficiency, effectiveness, and ethic) which is based on objective, subjective and intersubjective dimensions inspired by Nonaka and Zhu (2012).

3. PROPOSAL OF A MODEL FOR A SHARED CONTROL SYSTEM

² An organisation can only be understood by its ability to influence its environment, to be influenced by it, to influence itself (by deliberate transformation), and to adapt constantly to change. This systemic dimension of the organisation is summed up in the notion of auto-eco-re-organisation developed by Morin (1985).

ADAPTED TO MATCH THE CONTEXT OF THE HEALTH SECTOR

The systemic constructivist model for a shared control system adapted to match the context of the health sector supposes as a minimum:

- developing an organisation culture that favours shared control, reflected in humanist values that are consistent for both administrators and the professionals providing treatment, upheld by the executive management, shared by all, and appear to constitute the keystone of the organisation (the hologram principle);
- taking account of everyone's points of view in a process of mutual listening, in order to be able to develop innovative strategies (the dialogic principle), which supposes the implementation of arrangements based on collaboration and discussion among the different activities and hierarchical levels. A more global vision of the organisation fosters decompartmentalisation, cooperation, and regular discussions among the different jobs and levels of responsibility. This openness makes it easier to analyse feedback loops (in order to avoid the negative amplification of feedback);
- defining strategic objectives and implementing actions by enabling everyone involved to feed and read the control system, regardless of their job or hierarchical level. This is a prerequisite for taking all the parties' knowledge into account in order to bring out new strategies. Thus the actions arising out of the strategy are thought of in short-, medium- and long-term systemic terms (the recursion principle; auto-eco-re-organisation).

These three criteria are present in the proposed model for a shared control system; they are referred to as 'the 3 Es' for the dimensions of 'efficiency', 'effectiveness' and 'ethic' they represent; they are set out below.

3.1. The 'efficiency' dimension of the shared control system: respecting the demands of the supervisory authority and adapting to budget constraints

The positivist values present in Taylor's scientific work organisation are also to be found in the professional bureaucracies defined by Mintzberg (1978), to which health organisations are very similar. These bureaucracies are characterised essentially by a clear definition of hierarchy and authority, the formalisation of plans for drawing up strategy, their specialised, standardised work, formalised procedures, and control of the rules.

If a bureaucratic organisation is subject to rules imposed by the supervisory authority and drastic budget rationalisation, it tends to foster respect for the rules and large-scale cuts in the allocation of resources rather than seek out dysfunctions in order to reduce waste. Priority is given to efficiency rather than to projects (change, innovation, etc) that make great demands on resources and produce vague results that are not immediately visible. Health organisations are effectively bureaucracies where work is controlled if it is recorded when it has been carried out. It is of little importance whether what is actually recorded corresponds to reality: the record is all that counts (Mintzberg, 1989). Many professionals would agree with Mintzberg on this, particularly with regard to quality procedures (see below), because of the predominance of respect for rules to the detriment of the construction of a common project. The quest for efficiency becomes an almost exclusive purpose, at the expense of effectiveness, meaningfulness and "sensemaking" (Weick, 1993). The matter of removing meaningfulness may be explained by the disappearance of the human factor from the equation (Mintzberg, 1989; 2017), and the focalisation on facts rather than on values. "Modern science is based on the disconnection of the judgment of facts from the judgment of values, i.e. knowledge and ethic." (Morin, 2004, p.20).

Despite all these limits, our model defends an objective dimension of control, i.e. an analytical, rational dimension aimed as seeking efficiency, in order to:

- meet the demands of the supervisory authority which imposes a boundary system and a diagnostic system based on seeking efficiency which is reflected in the broad reporting presented in the first part of this article;
- pay attention to the allocation and use of resources in a context of budgetary constraint. Providing quality treatment and care is not ensured by eliminating control of the efficiency of practices (and of the organisation as a whole), as demonstrated by the decades during which health organisations in France spent as much as they wanted.

But as soon as such a position is defended, and given the limits of the bureaucratic model, it must be added immediately that the second dimension of the ‘subjective’ shared control model proposed is actually based on the quest for effectiveness.

3.2. The ‘effectiveness’ of the shared control system: evolving in a VUCA and hyper tetranormalised environment

A VUCA environment calls for a strategy, and therefore an interactive system, since “strategy is the only thing that can enable us to progress in the face of uncertainty and randomness [...] [It] is the art of using and incorporating the information that arises while an action is being carried out, of formulating action schemes instantly, and being capable of gathering together as many certainties as possible in order to face uncertainty” (Morin, 1990, p.178). If an organisation is to be able to adapt in a VUCA context **despite his hyper tetranormalization (Savall and Zardet 2013, Boje 2015, Cappelletti et al., 2015)** then organisational learning is the means of achieving such adaptation. If we consider that there is no ontological reality since it is a construct, then learning no longer concerns the acquisition of best practices but is itself a collective construct (thereby forming part of the very foundations of constructivist epistemology), as interactive control suggests.

But how is an ‘effectiveness’ dimension of any particular assistance in a VUCA **and hyper tetranormalised environment?** The answer to the question lies in the fact that such an environment requires health, social and medico-social establishments and services to:

- ensure the presence of a shared control system which systematically coordinates the quests for immediate results (diagnostic system and boundary system) and the creation of potential in the medium- to long-term (interactive system) (Savall and Zardet, 2008 ; 2013). The organisation could thus “reconcile two contradictory demands: ability to innovate, manage strategic uncertainties, grasp new opportunities, and promote the development of emergent strategies by means of interactive control; mastery of performance-critical variables and a stable sphere of activities that have reached maturity in the context of the implementation of deliberate strategies, using a diagnostic system” (Naro & Travaillé, 2010, p.61);
- constantly challenge routines (Levitt & March, 1988) and enter into the dynamics of organisational learning in order to be able to adapt rapidly (Argyris, 1993);
- consider and position the organisation within its ecosystem (Johansen, 2007).

If these conditions are present, social, medico-social and health services and establishments will be in a more favourable position to take up the challenges presented by a VUCA and hyper tetranormalised environment. They will therefore be effective, i.e. creative, capable of developing a vision (Senge, 2006) and a projective dimension giving meaning to the action (Weick, 1993), which is not always the case today, as demonstrated above.

Thanks to the subjective dimension of organisational control, volatility is counterbalanced by values and a long-term vision (a beliefs system), a strong, assured strategic orientation that is communicated to those involved in order to provide reassurance (Senge, 2006). Uncertainty is countered by understanding. Understanding one’s environment supposes, in a highly pragmatic way (Nonaka, Zhu, 2012), listening to both the internal players (staff, social partners, etc) and the external stakeholders (supervisory authority, associations of patients, etc) of the organisation in order to evolve (an ‘interactive system’). In turn, complexity is held

in check by experimentation and simulation (Simon, 1969). Lastly, ambiguity, which is a source of errors, requires that corrective adjustments (in the ‘diagnostic system’ and ‘boundary system’) be implemented rapidly (Hébert, 2009). The quest for efficiency and effectiveness is not enough to ensure that the players’ behaviours are adapted to the adjustments or changes suggested by a truly shared control system; that is why the model develops a third aspect, based on a quest for an ethical dimension.

3.3. The ‘ethical’ dimension of the shared control system: guiding implementation of the humanist values upheld by the health organisations

This last intersubjective dimension of shared control is based on living together, the projection of society, shared values, the common good - in a word, ethics (Nonaka & Zhu, 2012). However, bureaucracy supposes rational behaviour to be a finality (*zweckrational*), described by Weber as the attitude of a person who balances the end sought, the resources implemented to achieve it, and the possible consequences of an action. In fact, that person does not act either by expressing feelings or emotions, or by tradition (Weber, 2013), which is the opposite of the ethical values upheld by health professionals and explains the tensions described above.

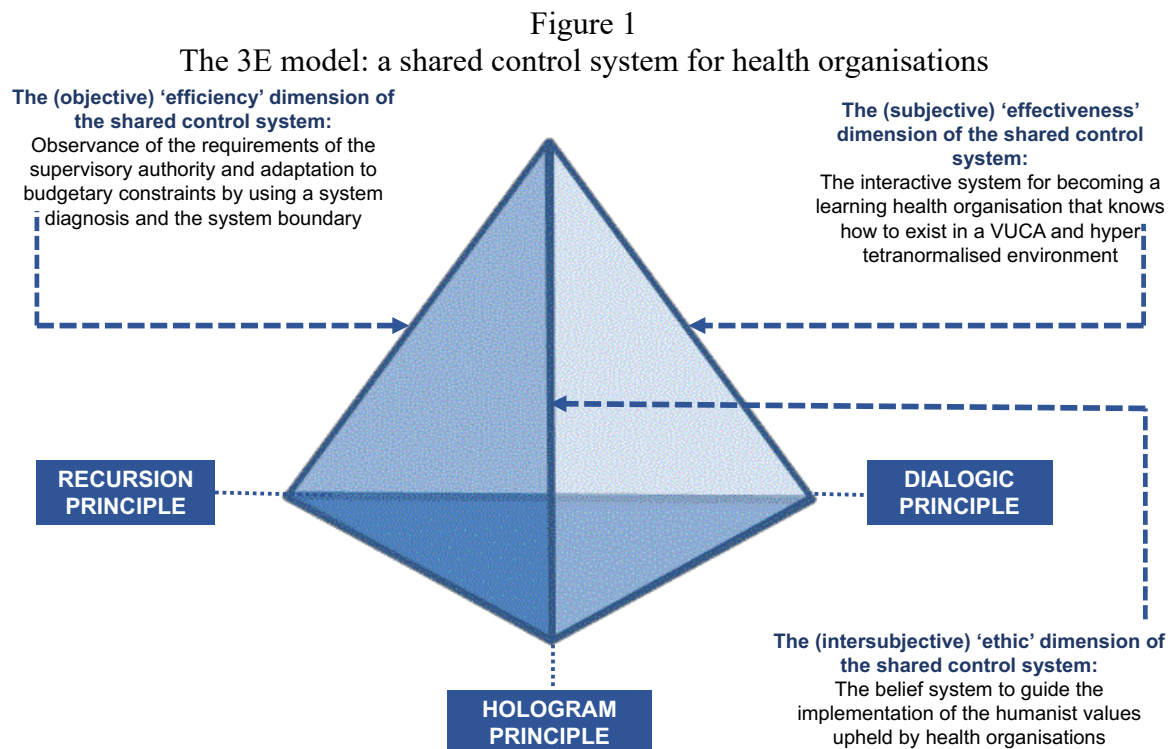
That is why the beliefs system is of major importance here, as it guides the implementation of values such as social justice and equity in order to return to - or indeed introduce for the first time - mutual trust between the managerial sphere (administrators) and the functional sphere (professionals). It needs to be recalled that within health organisations, ethics are based on the humanist values that were upheld by the *Conseil National de la Résistance* once the Second World War had ended, in its desire to implement “a comprehensive social security scheme aimed at providing all people with the means of existence whenever they are incapable of providing for themselves by working”³. That is why the preamble of the French Constitution states that the nation “shall guarantee to all, notably to children, mothers and elderly workers, protection of their health [...]”⁴.

According to Malmi & Brown (2008), culture is a key element in control systems, culture being characterised here not only by a humanist imperative but also by membership of a professional group (doctors, nursing staff, or administrators, for example) and respect for the rules supplied by the supervisory authority and the hierarchy. The challenge will be to reach beyond clan-based logics (Ouchi, 1979) and bureaucracy in order to introduce dynamic changes that are both horizontal and vertical. In our model, vertical exchanges are considered in both ascendant and descendant terms (for example, between technician, nursing assistant, nurse, health administrator and the person in charge of the treatment and in the opposite direction, to provide input for the making of decisions on the patient’s individualised treatment plan). Horizontal exchanges take place regardless of the hierarchical level and the department concerned (for example, the cook works with the doctor and nurses to consider with them menus suited to the diets prescribed, which are then validated by the dietician). These principles, which are not nowadays obvious in health services, appear nevertheless to be coherent in order to respond to the brutal, or at least frequent, changes that may take place within organisations.

³ See the programme of the Conseil National de la Résistance on the Wikisource.fr website; page [in French] consulted on 10 January 2017: https://fr.wikisource.org/wiki/Programme_du_Conseil_national_de_la_Résistance

⁴ See the French Constitution [in French] on the Legifrance.fr website; page [in French] consulted on 10 January 2017: <https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=LEGITEXT000006071193&dateTexte=&categorieLien=cid>
[English text at https://www.conseil-constitutionnel.fr/sites/default/files/as/root/bank_mm/anglais/cst3.pdf]

Thus the ‘ethical’ dimension of the model proposed appears to facilitate the permanence, completeness and continuity of the modelled shared control system in its entirety.



Source: Based on Simons (1990, 1995), Morin (2005), Nonaka & Zhu (2012), Savall & Zardet (2013), Bertezene (2018)

CONCLUSION: SUMMING UP THE LIMITS AND PROSPECTS OF THE MODEL PROPOSED

The various control procedures set up within the health, social and medico-social sectors all have more or less the same objectives, but they are not coordinated with each other because of a plethora of norms to be observed that have been added over the years, resulting in the production of reporting that is considered of little interest by administrators and their subordinates (hyper tetranormalization). The latter claim to uphold a humanist culture that is very frequently incompatible with the managerial logic of their administrators and the supervisory authority. As a result, this abundance and the superposition of indicators create confusion and reticence, both of which are harmful to the assessment procedure in general (Elbaum, 2009).

In this context, the article has looked at the possible morphology of a system of organisational control in order to both prevent the superposition and inconsistency of the procedures and inform strategic, organisational and operational decision-making (and thus make hyper tetranormalisation an asset and not a constraint). The proposal formulated defends the idea of the need for a systemic vision of the organisation in order to develop a single control system capable of coordinating and achieving the interaction of the various control-type inspections, assessments and procedures that nowadays underpin the internal and external control of these services and establishments. The model proposed is a three-fold shared control system comprising three interdependent dimensions centred on efficiency (objectivity), effectiveness (subjectivity) and ethic (intersubjectivity). The aim of the shared input and reading of information is to achieve greater relevance and faster decision-making by all (subsidiarity in

order to achieve greater agility) in an unstable environment. Consequently, the model supposes the empowerment of all (and therefore mutual trust and sufficient autonomy) with regard to both providing input and reading the information that allows control (indicators, working documents, etc). The aim of the 3E shared control system is to break away from the practices inherited from the bureaucracies that appeared in the early twentieth century in the health organisations and increased dramatically in scale after the Second World War, in the wake of the introduction of social protection and the emergence of a vast public sector (and participant in the public sector) in the health field. Such practices have indeed now become scarcely compatible with the evolution occurring in an environment which has become more volatile, uncertain, complex, ambiguous (VUCA) and hyper tetranormalizes Savall and Zardet 2013, Boje 2015, Cappelletti et al., 2015), and calls for organisational control that is more interactive (Simons, 1995) and directed at the co-construction of strategy- and decision-making to counter the negative effects of hyper tetranormalization.

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