

THE NEW NHS

An Ethnographic Case Study of the Role of Professionals in Policy Reform

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Abstract

The National Health Service (NHS) holds an esteemed position within Britain's 'welfare state'. Since its inception, however, it has been subject to near constant reforms, seemingly intended to balance public expectations with available resources. Successive governments have required professional collaboration to gain crucial popular support, and increasingly, general practitioners have been prioritised within reform initiatives.

Sociologists assert that professionals' reactions to reforms are often shaped by estimations of such reforms' influence on claims to professional status. Professionals react particularly defensively when they estimate that reforms challenge the foundation of status based on professional identity. Indeed, professions perceived as having 'weaker' professional claims may engage more diligently with such defensive work, and general practitioners have been particularly virulent opponents to reforms.

I spent eighteen months conducting ethnographic research into the role of GPs in the implementation of the reform initiative, *'The New NHS: modern, dependable'* (1997). I explored the translation of policy ideas into 'real' working structures, seeking to address a gap in the literature between considerations of the formulation of official policy rhetoric and evaluations of reform effectiveness. Data revealed 'clinical governance' and 'delegation of authority to local professionals' as key concepts in shaping local reform implementation. In particular, official policy rhetoric outlined initiatives as unproblematic, whereas the data illustrated their complexity.

Furthermore, contrary to expectation, interaction between GPs and the state was not overtly confrontational. Rather, local actors engaged multiple strategies seemingly intending to maintain locally formulated co-operation. Policy implementation was shaped more by efforts to protect existing local networks, than by professional efforts to defend against any one reform initiative. Professionals' engagement with policy objectives to protect their privileged status served to facilitate the operationalisation of ideas. The influence of particular local actors being such that they were often able to mould policies to serve their own agenda.

1. Introduction

“... ..what seems to have been relatively neglected, or perhaps underdeveloped, in Britain, is the detailed institutional and organisational analysis of health systems in practice, and studies which relate such analysis to broader changes in the welfare state.” (Flynn, 1992: 200)

In April 1997, Britain elected a new Labour government with an ambitious manifesto of health care reform. The electorate apparently perceived the cherished National Health Service to be in need of reform in order to address inequalities and inefficiencies that had developed under the previous Conservative government. Moreover, the market based reforms of the early 1990s had been unpopular, and were judged to have failed to bring about expected improvements to the system. In December 1997, the newly elected government released the White Paper, *The New NHS*, outlining their plans to operationalise election promises through a radical reorganisation of the NHS.

Political promises of health care reform are, however, hardly revolutionary. Indeed, the history of the NHS reveals that the system has been undergoing change initiatives constantly since its initial formation. Yet, such a history would also suggest that reforms tend not to actually ‘fix’ the problems for which they are introduced. Popular media representations certainly tend to portray reforms as failures. Rather than engage in overly simplistic evaluations of reforms based upon comparisons with official goals and objectives, it seems more valuable to give careful consideration to

the particular reform initiatives as they are introduced. The organisation of the institutions of the welfare state plays a significant role in defining the relationship between the state and its citizens, and reform initiatives offer valuable opportunities to observe efforts to shape this relationship.

With advances in medical technology and improvements in public health, so public expectations regarding health and health care have expanded significantly. For instance, health is now commonly conceived to be a basic human right. When (in the aftermath of World War II) the decision was made to establish the NHS as a system whereby comprehensive 'health care' would be delivered to all, free at the point of delivery, it was seemingly without foresight regarding the extent to which expectations and demands of such a service would increase almost exponentially. The central position adopted by the British state with regards to resourcing and providing health care has meant that, alongside increasing public expectations, have come increasing demands on the state.

Policy makers have often chosen to attempt to engage professionals in managing expectations put on the state. Professional status can provide a level of authority and trust that facilitate the management of public expectations. Professionals are charged with having important expertise and understanding regarding appropriately meeting people's needs. The delegation of resource allocation from centralised government to local professional control (a central initiative in *The New NHS*) may be one means by which the government can aim to reduce its involvement in and responsibility over a politically challenging arena.

Professional traits may also be useful for legitimisation efforts regarding proposed reforms. *The New NHS* carefully outlines an extended role for local professionals in determining resource allocation, seemingly intending to capitalise on the greater level of trust afforded to professionals than to either managers or politicians. Professional support for such measures has not, however, been particularly easy to acquire. Professionals have tended to conceptualise reform initiatives as undermining professional claims, rather than as offering opportunities for professional development.

General practitioners, proffered in the White Paper as the 'front line' professionals of the NHS, are central to this set of reforms. Focused reform attention on GPs is, a relatively recent phenomenon; earlier NHS reforms tended to concentrate on 'expensive', secondary services. The history of British general practice reveals a likelihood of considerable and constant professional resistance to change initiatives. The sociology of professions literature also predicts that general practice will be more defensive towards reform measures because of a somewhat more tenuous professional claim than their specialist colleagues.

In this research, I seek to explore the processes by which the government's politically contextualised reform ideas were translated into workable practice at the local level. I am chiefly concerned with the role played by local GPs in this regard. I will argue that previous analyses of policy reform have often underestimated the significance of local action, and that the level of local action is particularly relevant in relation to this reform because of the importance placed on 'decentralisation' in the policy documentation.

The New NHS framed many of the reform initiatives as attempts to ‘decentralise’ decision making, arguing that such measures would facilitate the transfer of control over health care decisions from centralised managerial structures into the hands of more knowledgeable local professionals. My hope is to expand understanding of policy implementation and the effects of such change measures for both professions and the state.

I chose to conduct an ethnographic case study because I felt that this was the most appropriate methodological approach to exploring the complex (and previously under-researched) process of reform implementation. I spent approximately eighteen months in one English health authority, following the change process through participant observations, ethnographic interviews and qualitative documentary analysis. I followed the transition from voluntary and locally instigated GP involvement in managerial tasks through to the formal introduction of mandatory, centrally determined structures for augmented professional contributions.

My approach allowed me to collect various perspectives and accounts of the reform implementation process in this locality. Through these data, I formulated a valuable understanding of local interaction regarding the interpretation and implementation of official policy objectives. While the decision to conduct a qualitative case study may mean that my findings are not easily generalisable on the surface level, I would argue that this approach revealed structures that are applicable to not only to other English health authorities, but also to other reform measures.

The Casterdale¹ data reveal a more complex negotiation of the decentralisation initiatives than is anticipated in the official reform rhetoric. Existing local structures of professional involvement were shown to shape the interpretation and adoption of the decentralised structures as outlined within the White Paper, and subsequent centrally issued instructions. Furthermore, I found that the delegation of authority to local professionals was not universal, but was rather tightly concentrated into defined task areas.

I observed several types of work being delegated to local GPs within the new structures, and will suggest that often these do not differ greatly from tasks already being undertaken from within locally formulated structures. Three factors emerged as key to the way that the decentralisation measures were implemented in this health authority district: the continued role of the health authority, support for local collaboration, and the increasing importance of centralised control structures alongside and on top of decentralisation initiatives. The decentralisation process can be at least partially understood in relation to the collective agendas of the three influential actors in this local implementation: central government, local management and representatives of the GP profession.

Alongside ‘decentralisation’, *The New NHS* also clearly outlines initiatives to increase the level of government control over health care – both in relation to standardising clinical practice and attaining measurable outcomes. Policy makers seem keen to direct resources towards practices that will enable certain quantifiable objectives to be reached. The White Paper carefully couches the goal of greater

¹ The pseudonym given to the area in which my research was conducted.

clinical control within notions of greater equality, accountability and efficiency.

These measures, however, also appear to be based on the idea that there is a potential benefit in continuing to frame the health service as essentially under professional control.

Although policy makers are careful to make assurances that *The New NHS* will not challenge the authority of medical profession, previous research warns that such governmental initiatives are still likely to meet with heavy professional resistance. The likelihood of such resistance may have prompted policy makers to emphasise the *professionally-mediated* system of clinical control. It may also go some way to explaining why the policy was bereft of implementation details in this regard.

The translation of abstract policy ideas into workable practices reveals much about the relative power of the relevant actors, as well as their continued role in society. The data indicated a tendency for the policy objective of augmented clinical control to be interpreted locally as an adaptation and formalisation of existing systems of seemingly ad hoc collegial audit. Such changes are beneficial in that they require only fairly modest resources, and run less risk of alienating professionals, thus possibly undermining public confidence in a professionally-led system.

Furthermore, data suggest that local GPs were often able to manipulate the policy agenda such that actual changes to working practice were greatly limited. One example of this was the extent to which collegial regulation was framed as being professionally empowering. This was largely achieved by avoiding any consideration of collegial sanctions, and by incorporating only a limited notion of clinical governance. Local GPs could not, however, completely control the implementation of

reform measures; one important limitation was GPs' restricted access to seemingly vital information. The issue of who controlled information emerged as a key issue to local control, with both central government and local management seeming to continue to hold more power than local professionals.

I will consider why greater state control over professionals in the health service might have been prioritised within the 1997 reform initiatives, and outline the ways in which the objectives of gaining greater government control were developed into workable structures. I will incorporate these changes into the existing literature on the professional claim of general practice, and consider both how the control initiatives may further GPs' agenda and the challenges that such reforms may pose.

The sociological literature outlines an expectation of high levels of confrontation between professionals and the state (largely represented by managerial staff at the local level) during periods of change. In contrast, these data strongly suggest that local implementation was largely defined by active efforts on the part of both managers and professionals to maintain cooperation and consensus, and to strengthen existing relationships. Local actors seemed to recognise that they stood to lose if co-operation was to break down, and therefore worked to avoid conflict that would necessitate an absolute resolution (thus differentiating a clear 'winner' and 'loser').

I will explore various locally instigated measures to avoid confrontation, and the engagement of various actors with such channels. I will also outline several instances in which the 'co-operation work' seemed to break down, and suggest that this tended to occur when one group was unable to appreciate greater utility from engaging in measures to support consensus than from more overt resistance. I argue that such

instances are often particularly valuable in delineating competing agendas, and actors' strategies in pursuit of their own position.

This thesis will conclude with a consideration of how these data might contribute to our understanding of policy implementation, as well as the continued role of professionals within our ever-changing society. I will make links between the case study data and both the existing sociological literature, and the larger policy context. I will integrate the official reform rhetoric with the local action as reflected in my data, and suggest why particular interpretations were deemed to be expedient. I will also explore the ways in which both the policy rhetoric and its local implementation may affect the future responsibility of the state in relation to health care provision, and general practice's continued claim to professional status.

2. The Pathway to *The New NHS* and to this research

In this chapter, I will outline my decision to spend just over a year in one English health authority researching general practitioners' role in the operationalisation of a national policy initiative. I liken this chapter to opening a set of Russian dolls; each step is nested within those previous. I begin with the 'big' ideas that both frame, and have driven, the present study. I then move 'inward' to the existing sociological literature whose predictions and hypotheses raised the questions that I sought to address. Finally, I focus on the particular 'case study' upon which I embarked.

This process is important because this research would be of limited significance if considered in isolation. Little insight is likely to be gleaned from simply observing one group of local doctors and managers working through a single set of organisational reforms. The significance of my research rather rests in the connections and relationships that can be established between these data and existing knowledge. What ideas does my research challenge? What suggestions might it reinforce? Which gaps does it start to fill? Modest pieces of research such as this often establish the foundations for new knowledge; small studies build upon one another to challenge and shape what is already known, and allow researchers to expand into uncharted territory.

I intend this chapter to lead the reader from my initial interest in the importance given to health and health care in contemporary British society, through to my decision to study the role played by general practitioners in the local implementation of one particular reform initiative. My thesis can be seen as cyclical; I start with society's

larger structures, then I focus on particular social interactions, and finally I develop hypotheses as to how such interactions may contribute to present and future structures.

This thesis is primarily concerned with the interface between policy implementation and the organisation of the work of general practitioners, as outlined within the 1997 White Paper, *The New NHS: modern, dependable*. Recent NHS policy has prioritised the role of general practitioners in determining the service's effectiveness. From such a perspective, gaining greater control over the primary care sector is presented as being essential to all attempts to regulate costs (Calnan and Gabe, 1991).

2.1 The importance of studying health care

".....health care is one means by which society as a whole contributes to the social inclusion and autonomy of individuals." (Milewa, Valentine and Calnan, 1999)

I do not intend to provide a detailed discussion of what 'being healthy' means either in, or for, today's society. Or, how the health care system contributes to the 'attainment of health'. Instead, I will begin this consideration of NHS reform by asserting that health is a social construction based upon (and reflecting) societal ideas and values. From such a constructionist perspective, systems of health care are seen as reflecting our notions of what is meant by both health and health care. In turn, health is largely shaped by our perspectives of appropriate care. Strauss et al (1983) propose that if one hopes to fully understand the work of managing illness, it is important to consider the nature of contemporary illness. Where does care take place? What does care entail? How is medical knowledge constructed? I will provide some

rudimentary comments regarding contemporary British notions of health and health care, although a detailed discussion is beyond the scope of this study.

Cox (1998) suggests that we can learn a great deal about the meaning of citizenship by considering the changes occurring for various welfare states. “..... *treating the welfare state as the dependent variable still offers a fruitful line of research.*

.....*Theoretical and comparative research that explores the degree to which such changes have taken place in individual countries can instil general useful insights.*”

(Cox, 1998: 14) I would contend that it is also important that we improve our understanding of society’s perspective on ‘health’ as a way of providing insight for any consideration of a health care system.

As society has become more able to problem-solve within the medical realm, so a discourse has developed in which health is seen as a basic human need, and medical care has become perceived as a social right (Frenk and Duran-Arenas, 1993). The importance placed on health and subsequent health care have been incorporated to a certain extent into our notion of human or citizenship ‘rights’, the provision of which society will generally be held responsible (Butler, 1973). Health has become conceptualised as a fundamental, universal entitlement, and the idea of health as a social responsibility is now deeply embedded in the inner consciousness of many countries (Langley, 1996). The protection and maintenance of rights (such as health) are often accomplished through formalised systems – such as state run health care, education or social services. As our understanding of these ‘rights’ expands to encompass more of our daily lives, so the formal institutions of the state have tended to expand to accommodate this. “*The welfare state is the high point of a lengthy process of the evolution of citizenship rights.*” (Giddens, 1998, pg. 10).

In the aftermath of World War II, the British government set out to build a Welfare State on a base of greatly strengthened state institutions, at the heart of which was The National Health Service (Pamplung, 1998). The prevailing historical rhetoric is that these institutions both reflected and were shaped by developing notions of citizenship rights. Institutions are established and continue to be organized based upon how citizens are generally presented and perceived (Cox, 1992). Thus, the ideological context set by World War II was instrumental for the 'new' British state.

The centrality of the NHS to the British Welfare State has contributed to this institution serving as the primary focus of much of the work to redefine notions of citizenship (Milewa, Valentine and Calnan, 1999). Thus, as we develop our perception of citizens as consumers, clients, patients, students (or perhaps even primarily as recipients of benefits), so this will shape both what is expected of services, and what they might successfully provide.

The rhetoric of an intricate interplay between societal views of citizenship and the resources provided by the state is, however, open to question. Perceptions of citizenship rights, and the relationships between citizens and the systems established to support such rights are deeply embedded. Butler (1973) challenged the extent to which developing conceptions of citizenship rights serve to shape the service in any meaningful way. Although superficial structures may change with some frequency, their ideological foundations tend to stay the same. Once established, state structures become an integral part of society, and are generally allowed to develop with relatively little thought as to how well they continue to meet the needs for which they were established.

Beyond abstract connections to notions of health and citizenship, health care is also important because of the major role that it now plays within our economic system (Hollingsbaum; 1988, Langley; 1996). Economic growth generates demand for additional health care services, and in an expanding economy, health care has considerable potential for economic activity and expansion. An expanding health care system will (presumably) lead to amplified notions of health and health care. Manning (1994) proposes, however, that the level of inter-country variation of GDP spent on health care suggests that the relationship between economic growth and the expansion of the health care market is one of complex correlation, rather than simple causation. Growth does not stem simply from citizens/consumers/patients demanding more services, the medical profession is also situated to generate such demand through clinical innovation and political power.

2.2 The role of the state in shaping British health care

Since the beginning of the nineteenth century, foundations have been laid for the British state to assume an increasingly central role in the provision of citizenship services² (Hanlon, 1999), such that the government now plays an active role in the planning, financing and providing of various services. In the case of health care, the state's contribution has developed largely into the services now provided through the National Health Service (NHS).

Many professionals (such as general practitioners and solicitors) initially perceived the state's expanding role in the provision of welfare services as posing a serious

challenge to their own status and power (Hollingsworth, 1988). Such professionals (such as solicitors and doctors) had historically dominated the relatively unregulated realm of social services, largely by closely aligning themselves to power as caregivers to wealthy individuals. British professional resistance to the idea of state involvement in the provision of welfare service tended, however, to dissipate relatively quickly³. The contributions of such a massive financing body greatly increased both potential for demand, and resources for dealing with it. Such an expansion offered greater professional opportunities, particularly serving to reduce fierce competition between practitioners (Hanlon, 1999).

In systems (such as in Britain) where welfare services are financed through general taxation, balancing the role of the state in relation to health and the provision of health care can become a difficult, but crucial, task. In such instances, a varying (but almost always very considerable) proportion of the state's annual budget is spent on providing health care for the population. The importance of health to the population can encourage governments to work to demonstrate their prioritisation of health care services. This official stance need not, however, necessarily actually reflect an increase in the amount of money that a government is willing to spend on delivering such care. Rather, the demonstration is concerned with an assurance of an acceptable level of health for the general population, while also creating and maintaining a politically acceptable system through which to provide the level of care necessary to sustain such conditions.

² Such as health care, education, and social welfare

³ Outside Britain, however, professionals have maintained general opposition to increased levels of state involvement in financing the provision of services (Mays, 1997: Freidson, 1975).

The NHS has a limited ability to provide sufficient care to protect citizens' rights to health, in the face of seemingly insatiable demands. Furthermore, the system is seemingly plagued by competing philosophies as to the basis upon which such care is most appropriately provided. The conundrum of whether the service should seek to provide the best possible care for each individual (the individualistic perspective generally held by general practitioners), or to provide a standardised level of care across the entire population within the means available (the more collectivist position adopted by public health) remains unresolved (Fry, 1988).

The overarching popular notion is that the NHS will provide the magic of modern medicine for all citizens. Thus, the NHS 'suffers' from a gap between rapidly growing public expectations about what the state should be providing, and limited system capacities. Moreover, the cost of meeting increasing demands will continue to fall upon the government until a way is found in which to responsibilities for such tasks can be shifted into other areas, or onto other bodies (Harrison and Ahmad, 2000).

Given that the state cannot deliver services ad infinitum, and without some consideration of cost, the notion that the NHS can successfully address all of Britain's health problems is one of fiction.

Klein (1995) asserts that the role of the NHS is to serve as a tool for rationing and distributing scarce resources. With the formation of the NHS, the British government formally adopted a collectivist approach to the provision of health care. Policy makers couched the proposed reforms in (ultimately) the very successful rhetorical perspective of 'comprehensive health care for all'. Early NHS budget projections would suggest, however, that the proponents of the new service did not fully appreciate the demands that would come to be made of the system. There seemed to

be an under appreciation of the extent to which the service would form the basis for further demands, rather than satisfying existing needs.

The establishment of the NHS incorporated the general assumption that it was possible to provide a health service that could secure the mental and physical health of the population (Kelly and Glover, 1996). Policy makers proposed that once a level of ‘good health’ was delivered, the demand put on the service would decline, although it is somewhat questionable whether policy makers ever actually believed this to be true (Webster, 1988). In hindsight, however, we are acutely aware that demand never fell, but rather that expectations and costs grew alongside rapidly advancing technologies (Manning, 1994).

The success of the foundation rhetoric has played an important part in shaping public expectations regarding the NHS. Kendall et al (1996) suggest that beyond the policy’s official rhetoric of providing comprehensive health care for all, the formation of the NHS was also driven by the technical goal of acquiring an efficiently managed health care system. The initial ‘blueprints’ for the NHS were as pragmatic as those of any future reforms; the popularity of the ideological position within which they were couched was, however, perhaps more potent than any that would follow.

2.2.1 Summary : The importance of a changing context for health care provision

The role of the state in shaping the provision of health care is both interesting and complex. It cannot, however, be properly considered in isolation from other factors.

Starr (1982: 8) states that *“The development of medical care, like other institutions,*

takes place within larger fields of power and social structure.” As outlined above, popular conceptions of both health and health care are contextually and temporally bound. To a certain extent, context determines the system. If public expectations change, so the system will change – if it is to continue to fulfil expectations. I would argue, however, that the structure of the system is also influential in determining expectations. In either regard, the history of the health care system is closely entwined with the development of its larger historical context.

In order to build a better understanding of both why and how the present NHS is structured in its current form, and the direction in which the system may develop, one needs to appreciate the influence of the social context on the organisation of the NHS, as well as how the historical ‘background’ has shaped the development of the system. Furthermore, Harrison and Ahmad (2000) suggest that achieving sustainable control over the medical profession represents a crucial measure of state control at the end of the twentieth century and beyond . Thus, careful case studies of reform initiatives (such as *The New NHS*) may provide valuable analysis.

2.3 Why study Health Care ‘Reform’?

2.3.1 Change is increasingly perceived as a ‘normal’ organisational state

Most modern governments have experienced a “recent history of exceptional growth and change” (March and Olsen, 1983; 281), and much of the work of contemporary government involves managing change. Change is increasingly seen as the norm, and the public has come to expect organisational ‘development’ rather than static systems. Indeed, Hammer and Champy (1993) defined the late twentieth century as ‘The Age

of Re-engineering'. Such general expectations of change fuels the felt 'need' for health care reform, both requiring and justifying near continuous reform activities. Freidson (1975), perhaps somewhat cynically, observed that every period in history tends to find it necessary to declare itself in a state of crisis. The increasing normalisation of change seems likely to intensify this perceived need. Policy makers present reform initiatives as 'solutions' to existing contradictions or difficulties, and in this way reform measures can be very politically expedient. Thus, an informed understanding of policy reform should incorporate the significance of the process of organisational change in and of itself, as well as the idea of reform as a response to either changing conditions or a shifting context.

One might argue, therefore, that much of the administrative reform that has been introduced within the NHS reflects rhetorical activity, rather than any actual changes to practice (March and Olsen, 1983). Health care reform may often suggest the need to demonstrate legitimacy, rather than to achieve any 'real' change'. To this extent, the concept of 'reform' has become increasingly problematised within the sociological literature, and subject to more detailed analysis (Ferlie, 1997). Reform is therefore often seen as a value-laden term of persuasion – rather than a description of change that is, in itself, moving towards a self-evident good (Ferlie, 1992).

Hence, the history and development of the NHS can be conceptualised as constant organisational adjustments necessitated by the NHS' initial rhetorical success. The notion of 'reform' is simply a further rhetorical device employed by politicians to bolster support for their desired changes. It may therefore be that the creation of an illusion of progress is often a central, if tacit, reform objective.

Britain's seemingly endless search for a balance between health care demands and available resources is mirrored in many other nations (most prominently, the US). Klein (1995) defines health care reform as one of the "worldwide epidemics of the 1990s" (p. 299). Furthermore, Mechanic (1975) proposed that as a 'medical world economy' has developed, so many recent reforms across different countries draw on common core ideas (such as making greater use of market incentives). When such 'borrowed' policy ideas are inserted into different contexts, however, actors are likely to interpret and implement initiatives in ways that reflect both structural differences and actors' specific perspectives (Light, 1997b).

2.4 The key role of professionals in policy reform

Particular actors often play a crucial role in the implementation of policy. Indeed, the perspective of local actors often serves as a 'lense' through which centrally formulated policy should be seen in order to understand many of the officially unintended and unforeseen consequences, the effects of which often cause policy to be dismissed as having failed. It seems likely, however, that despite the frequency with which such 'failures' are seen to occur, both health care reform itself, and the application of policies from one context to another are likely to continue. Analyses of reform rhetoric and its relation to particular change initiatives therefore offer potentially valuable insight. Better understanding may be gleaned from considerations of the mechanisms established to deliver the initiatives, as compared to those outlined in official policy documentation.

2.4.1 The state uses professionals to manage its growing remit

The state's role in providing services for its citizens has become extremely complex, and is also seemingly in the process of constant expansion. Halliday (1987) proposes that this expansion has led to the state becoming increasingly overburdened with citizens' expectations with regards to its legitimate remit. Rhetorical reformulation has been one important technique adopted by the state to limit this expansion, and reform programmes have a considerable role to play in such efforts.

Professionals are often central to the solutions proffered by policy makers to quell demands being put on the state. Reform initiatives tend not to overtly abdicate state control over particular realms, but rather to delegate management to professionals who are publicly defined by a sense of vocation and valuable technical expertise. In this way, the profession and the state enter into a 'regulative bargain', in which the profession is granted monopolistic control over an area of work in return for an agreement to take on the responsibility for ensuring the quality of the work with which they are entrusted (MacDonald, 1995: Allsop, 1995). In this way reforms may offer professionals a valuable opportunity to attain greater autonomy over their own practice, a central element to professional power (Wolinsky, 1993).

Hence, often as increasing pressures are placed on the state's resources, these will contribute to a devolution of state responsibilities and functions to professionals, in order that the state might maintain a semblance of control over an expanding jurisdiction (Halliday, 1987), and continue to oversee an ever more complex set of structures. Thus, the capacity of the state is not considered as pre-determined, but

rather partly rests on the constantly developing relationship between the state and the professions (Johnson, 1982).

Examples of increasing delegation of responsibility from the state to professionals are abundant. In the UK, doctors and nurses are being asked to become increasingly involved in the governance of health care, teachers are expected to engage in the work of defining and monitoring educational standards as well as to teach, and lawyers and accountants are being made ever more accountable for defining the nature of their work, as well as the work itself. One way to interpret such involvement of professionals in politically sensitive measures is as attempts to temper public resistance, and to devolve responsibility for potentially unpopular action away from central government (Ham, 1998).

One aspect of such 'delegation' central to this thesis is the extent to which the work of defining the concepts of 'health', 'illness', and 'health care' have been (and continue to be) entrusted to the medical profession. These tasks serve to provide doctors with an important source of influence; professionals' definitions tend to be accepted by the public, and subsequently become the concepts upon which the service is based (Johnson, 1995). Indeed, Starr (1982) states that society's dependence on professions has become increasingly pertinent; we increasingly rely on professional interpretations in order to understand the world, and generally defer to experts' judgement. This acquiescence can be seen as essentially voluntary subjugation to professional agendas. *"Professionalism isa system of regulating belief in modern societies"* (Starr, 1983: 16). Furthermore, Hughes (1971: 424) stated that, *"Professionals do not merely serve; they define the very wants which they serve. Thus, the old dictum that professions fulfil the basic wants or desires of the people*

and society is much too simple.” Thus, professionals hold powerful positions in contemporary societies.

It is also significant that professional privilege is largely secured by the influence of the elite who sponsor it (MacDonald, 1995). Although professionals maintain powerful positions, their autonomy is granted by the state, rather than being something which they might demand. The state remains powerful because it has the ability to both grant and deny autonomy, although its reliance on professionals to manage aspects of its remit is a significant limitation. Thus, a system of power networks between the state and professions has developed that is inevitably intertwined and messy (MacDonald, 1995)⁴.

Furthermore, Larkin (1983) contends that state involvement in health care provision serves to both constrain and consolidate medical authority. The salary levels of doctors and price of prescription drugs are relatively low in Britain when compared with the US and other Western European countries, (Klein, 1995b). Thus, state involvement can be seen to both constraining as well as underpinning the power of the medical profession. The direction of causality is not always particularly clear.

2.4.2 NHS reform challenges professional power

The specific strategies adopted by the state in relation to the organisation of civil society are key to the scope of professionals’ power (Frenk and Duran-Arenas, 1993). Hughes and Allen (1993) suggests that most NHS reform can be understood as attempts to increase or improve state control, and to bring doctors and managers under

a common framework of accountability. Indeed, recent policy reforms have tended to be framed around standardising clinical practice, as well as augmenting government control over medical practice. More stringent control measures have been identified as important to the project of reducing (or at least controlling) costs, as well as to maintaining greater influence over how government resources are spent (Hollingsworth, 1988).

As outlined in the previous section, alongside the formation of the NHS, the British state and medical profession built a relationship in which control over health care provision was largely delegated to the medical profession. In turn, the clinical autonomy that this relationship fostered became seen as critical for the professional status of British doctors (Larkin, 1993). This arrangement also liberated the state from some responsibility, but resulted in the state relinquishing considerable control. Thus, over time, state control over healthcare spending has become (at least seen to be) increasingly tenuous. As a result, there have been increasing efforts to contain costs and to restrict medical autonomy (Flynn, 1992: 51), such that such controls now tend to be prioritised in considerations of the system.

Reforms that incorporate professionals into managerial roles have been identified as one effective means by which the state might achieve greater financial control (Freidson, 1975). Strengthening systems of professional self-regulation has been one of the most prominent facets of such efforts. The privilege of self-regulation is a cherished concept for the medical profession (Moran and Wood, 1993), and it would seem that doctors are increasingly being called upon to publicly consider and evaluate

⁴ I will expand on these points in Chapter 4.

colleagues' practice. Increased professional regulation has largely taken the form of a prioritisation and formalisation of existing structures of collegial control.

A certain amount of professional stratification has been identified as one likely outcome of this increased scrutiny (Freidson, 1983). Stratification may serve to challenge the intra-professional equality that has been seen as such an important factor in the creation and maintenance of a professional identity, as well as 'colleague loyalty', and collective values. This stratification may, in turn, challenge professional efficacy and the strength that professionals gained from their homogeneity (Johnson, 1972).

As well as seeking greater control over medical practice through increasing the power of professional regulation, policy initiatives (and particularly *The New NHS*) also appear to be structured with the intention of incorporating professionals into managerial decision making. Clarke, Cochrane, and McLaughlin (1994) maintain that the ideology of 'managerialism' (that is based upon devolution, decentralisation and the fostering of a culture of collective and inclusive responsibility) is becoming increasingly important within health care provision; systems that are organised on this basis would seem ideally suited to professional input. Traditionally, however, managerialism and professionalism have been conceptualised as oppositional philosophies, and initiatives that have sought to increase the managerial aspects of professional work have been strongly resisted.

Reform initiatives designed to increase state control over medical practice have tended to be multi-faceted, and subject to considerable sociological analysis⁵. The present research will focus upon the extent to which *The New NHS* influenced the processes of local decision-making and systems of professional regulation. This focus reflects the stated concerns of the policy initiative (*The New NHS*), and likely challenges posed to the professional agenda, as identified through the sociological literature.

2.4.3 General Practitioners are central to the NHS

The reform initiative considered in this study (*The New NHS: Modern, Dependable*), focuses, to a large extent, on the role played by general practitioners within the NHS. The NHS has recently been declared to be ‘primary care led’, with GPs ‘at the helm of the ship’. Thus, the ‘political’ power of general practice in relation to the success of policy initiatives should not be underestimated⁶. As early as 1968 (when the NHS was generally conceptualised as being dominated by specialist interests), Owen (1968; 20) warned that, “*No reform of the health service can hope to succeed unless it carries with it the 20,000 general practitioners who provide the essential and most sensitive primary link between the individual and the National Health Service.*” GPs’ position on ‘the front-line’ with patients, as well as their gate keeping role in relation to secondary and tertiary care makes them potentially very influential players in determining how the system operates⁷.

⁵ Detailed discussion of this literature is superfluous to the purpose of this chapter.

⁶ Horobin (1983) suggests that the continued importance of British GPs in an age of ever-increasing specialisation is a paradox to be explained. It would appear that Horobin perhaps underestimates the increasing importance of primary care internationally, as well as in the UK.

⁷ I recognise that the extent to which GPs are actually ‘front-line’ in comparison with other members of the primary health care team is questionable.

The role of primary care, and GPs in particular, within policy reforms is an interesting and important aspect of NHS development. Although the NHS has been undergoing near-constant review since its creation, it was not until the mid-1980s that GPs were prioritised within a reform initiative. Before this time, policy makers seemed to view primary care as the 'inexpensive' arm of the system, and an area where few substantial savings were possible. There has, however, been growing worldwide interest in primary care and general practice (Fry, 1988), and this attention has been reflected within recent NHS policy. A system in which primary care is prioritised may offer the potential to provide a cheaper, more effective and efficient health service. Primary care is expected to work effectively to prevent disease and promote health, and to reduce the demands that are placed on the service.

Regardless of the level of reform attention that they have received, GPs have always been central to the effectiveness of the NHS; their role as 'gatekeepers' (or filters) to more expensive, secondary services is vital to NHS efficiency (Light, 1993). In addition to controlling the demand placed upon the secondary services, GPs are also important because primary care practitioners deal with the vast majority (over 90%) of all 'ill health episodes' (Bryden, 1992)⁸. Furthermore, as noted above, medical professionals tend to hold strong positions of authority, respect and trust within the community. General practitioners are therefore frequently charged with the practical implementation of reform measures, and are both formally and informally called upon to explain and interpret the likely effects of any changes for their community of patients.

2.4 The Professional History of General Practice

GPs have historically reacted with considerable hostility to proposed health care reform measures. Moreover, GPs' professional history has created conditions that do not facilitate their easy incorporation into many reform initiatives.

“To understand a given structural arrangement, like professional sovereignty, one has to identify the ways in which people acted, pursuing their interests and ideals under definite conditions, to bring that structure into existence.” (Starr:1982, p. 7)

GPs' hostility to reform measures can be (at least partially) accounted for by general practice's somewhat tenuous professional claim. GPs have often interpreted changes to organisational structure as potentially undermining established claims to professional status. Hughes (1964) proposed that although professionals have tended to benefit from changes to organisation of their work, they have frequently been made uneasy by such transformations.

An occupation's ability to attain and retain a professional identity has become an important source of power and control. Johnson (1972: 32) stated that “professionalism is a successful ideology, and as such has entered the political vocabulary of a wide range of occupational groups who compete for status and income”. Professional status is also often key to the ability to restrict the market and protect practitioners' income (Burrage, 1996). The sources of power available to

⁸ Although much of this work will be done by community and practice nurses and other non-medical health care professionals.

occupational groups who make such professional claims are, however, an element often not given significant consideration in policy analysis.

Claims of professional status derive (at least to some extent) from the work with which one is engaged— where this work is done, with whom, and to whom.

Explanations for the position of contemporary general practice have their roots as far back as the mid-nineteenth century. GPs' professional claim has been shaped by the nature of their work, their relationship with fellow medical specialists, their clientele, as well as their history both within and preceding the formation of the NHS. The professional history of general practice has also been shaped by the relatively low status of GPs in relation to hospital doctors (Honigsbaum, 1979), and GPs' historic financial dependence on their patients (Calnan and Gabe , 1991). These factors have shaped the relationship between the state and general practice, and GPs' reactions to various policy initiatives.

The ability of a profession to exert collective influence can also be seen to rest on their demonstration of a *knowledge mandate* (Halliday, 1987), and the associated exertion of influence both within and over a defined area of expertise (Bucher and Strauss, 1961). The ability to demonstrate a distinct and unique area of expertise empowers professionals - "*Professions have no intrinsic resources other than their command over a body of knowledge and skill that has not been appropriated by others.*" (Freidson, 1993a: 62). Demonstrating an area of specialised knowledge is central to establishing and maintaining professional autonomy – which is, in turn, essential for making a claim to further professional privilege (Freidson, 1970). The professional claim of general practice, however, faces significant challenges in relation to such a mandate on at least three fronts.

First, GPs do not have a single area of work over which they can claim distinct expertise. The ability to define and defend a particular domain is often seen as central to making a successful claim to professional status (Freidson, 1970: Burrage, 1996). A GP's work is (by its very definition) *general*, and for any given area of work there are specialists who can claim greater expertise. There has therefore been a tendency to conceptualise GPs' skills and knowledge as being little more than the 'common knowledge' that is held by all doctors; knowledge that is superseded by all specialist expertise.

The development of a referral system between GPs and specialists in the NHS has been based upon a discrete division of labour. The referral system has been beneficial for GPs to the extent that it has defined distinct and supportive roles for both GPs and specialists within the system, thus reducing competition for patients. The system has, however, also somewhat confined GPs to the work of preliminary diagnosis and the treatment of common conditions (Fry, 1988). Patients tend to present GPs with relatively undefined and unselected packages of health problems (Fry, 1983). GPs are therefore sometimes seen as doing little more than separating the medical 'wheat from chaff' (Jeffreys and Sachs, 1983: 223); GPs are left dealing with social problems, minor ailments and medical administration, and having to pass 'real' medical cases on to specialist colleagues⁹.

Johnson (1972), on the other hand, contends that the key to professional power is being seen to possess valuable skills and knowledge – rather than being able to define

⁹ 'Real' as defined through GPs' biomedical dominated training.

a distinct area of autonomous control (i.e. professional power rests more on one's relationship with the patient, rather than on one's position in relation to colleagues). Since the medical profession has chosen to align itself with a scientific model of knowledge for its cognitive base (Larson, 1978; Honigsbaum, 1979), the 'hypothetical-deductive model' has been adopted as the dominant practice paradigm.

The doctor's role has become defined as investigating the cause of disease, engaging in diagnostic work, and overseeing treatment (Jeffreys and Sachs, 1983) – along the lines of a scientific experiment. GPs' professional history is troubled because their work does not sit easily with such an approach. Only rarely are GPs presented with a biomedical disease in isolation from social factors (McWhinney, 1996), and quite often GPs are not able to 'fix' the patient such that they do not return for additional treatment. These discrepancies have meant that GPs' work has been less likely to be recognised as skilled. Instead, it tends to be trivialised, and portrayed as unexciting and unrewarding (Jeffreys and Sachs, 1983)

"It is also recognised that in the medical profession the general practitioner's skills are not even predominantly those of a skilled technician, but refer to the ability of the practitioner to relate in a warm and personal way to the patient who is seeking reassurance and a listening ear at least as much as a specific diagnosis and adequate treatment." (Johnson, 1972: 35)

Furthermore, unlike hospital medicine, the establishment of the NHS did little to standardise GPs' practice (Stevens, 1966; Owens, 1968). Fry (1983) asserts that general practice is defined by practitioner individuality, whereas having a homogeneous identity has been identified as a powerful tenet of professional

authority. Not only do GPs lack a strong claim to professionalism based upon their general remit, their claim has also been weakened both by a lack of practice uniformity throughout the system and by their tenuous link to the scientific paradigm.

One approach that British general practitioners have taken to defend themselves against such challenges has been to emphasise their *holistic* knowledge of the individual patient as, in itself, a form of specialisation (McWhinney, 1996). This claim draws upon the idea that there are both social and biological determinants of health, and thus there is value in a practitioner who has skills appropriate to both realms (Armstrong, 1979; Fry, 1983). Because GPs' work sits at the crossroads between biomedical disease and socially situated illness, they are able to act as individuals with whom patients might share the burden of their illness, as well as witnesses to patients' illness accounts (Heath, 1995). This role could, in turn, be conceptualised as an area of unique expertise.

Such a 'holistic' approach has not, however, been a particularly effective approach to protecting professional status. First, there are no boundaries around 'holistic' knowledge that can be successfully guarded¹⁰. Furthermore, the notion that medicine incorporates 'social' aspects of health, as well as medical or clinical elements, is problematic. The standard biomedical model of illness allows little room for 'social' determinants of health. In an age where 'science' rather than the social is the dominant paradigm, the demonstration of expertise over the 'social' aspects of illness is unlikely to add significant weight to a successful professional claim.

¹⁰ The 'non-clinical' aspects of health have also traditionally been areas in which other health care professionals (such as nurses, health visitors or social workers) have been dominant. It may be that GPs also face more established 'experts' in this realm.

GPs' tenuous claim to both an acknowledged and respected unique skill base *and* a definable work remit seems to have contributed to their tendency to emphasise the importance of autonomy within their professional claim. The protection of individuals' freedom over daily practice has been understood to have shaped the history of general practice, particularly in reaction to proposed reform initiatives (Honigsbaum, 1979).

Within general practice, there has been a tendency to interpret professional 'autonomy' in terms of 'individual freedoms', rather than collective privilege. GPs have incorporated such notions into efforts to protect their independent contractor status, rather than collective status. Starr (1983: 12) however, states that "*Doctors and other professionals have a distinctive basis of legitimacy that lends strength to their authority. Professionals claim authority, not as individuals, but as members of their community that has objectively validated their competence. The professional offers judgment and advice, not as a personal act based on privately revealed or idiosyncratic criteria, but as a representative of a community of shared standards.*"

GPs' tendency to interpret autonomy in relation to *themselves as individuals* seems to have prevented them both from appreciating, and taking effective and collective action against other potentially threatening changes.

I will now briefly outline some the key events that have affected general practice and contributed to its present position. I will focus on the reaction of general practice to different reform initiatives, as well as the effects that such reactions have had, and the extent to which reactions can be attributed to professional claim making. This focused and brief history will begin with the 1858 Medical Act, an event commonly referred

to as the ‘starting point’ of modern British medicine. The roots of general practice are, however, also deeply embedded in the position and history of GPs’ professional forebearers (Fry, 1988)¹¹.

2.5.1 Key events in the history of the English GP profession¹²

The 1858 Medical Act established state registration for doctors, an event that brought legitimisation for the work of some practitioners and not others. Up until this point, medical practice had been fairly unregulated. With the creation of state registration, however, boundaries around what was considered to be legitimate medical practice as well as those who were legitimate medical practitioners became more tightly defined (Moran and Wood, 1993).

Through the Medical Act, and subsequent state registration, a relationship was forged between the state and the medical profession that forms the foundation for the enduring mandate of the medical profession. Practitioners who the act defined as ‘legitimate’ were consequently given responsibility for both defining and defending the realm of medical practice. Furthermore, the 1858 Medical Act formed the basis for state-licensed, professional self-regulation (Moran and Wood, 1993) through the establishment of the General Medical Council. The formation of this institution provided the medical profession with responsibility for, and authority over, the standards and quality of medical practice. At the same time, through such measures,

¹¹ When medical work was divided between surgeons, physicians and apothecaries, with little state involvement, the social class of one’s patient was central to the social standing of the practitioner (Stevens, 1966). Physicians held powerful positions as the doctors to the upper classes. GPs, however, gained influence through their association with the expanding middle classes.

¹² This section is not intended to provide a comprehensive history of English general practice, but rather to ‘flag up’ some of the key events that have shaped contemporary general practice, and will

the state was essentially able to relieve itself of the burden of monitoring the medical domain.

The passing of the 1911 National Health Insurance (NHI) Act was another key event in the development of general practice. The NHI Act instituted a state supported medical system, through which a limited range of medical services were made available for approximately one third of the population¹³ (Honigsbaum, 1979). This Act also established a more concrete role for the state in the provision of health care for the general population, and placed GPs in a pivotal position in relation to delivering such care. Over time, the panel system originally established through the NHI Act grew to incorporate nearly 90% of British GPs.

The NHI Act served to increase GPs' economic security, as it released them from the controls of private and contract patients (Calnan and Gabe, 1991). GPs were no longer at the mercy of the Friendly Societies and Collectives in relation to defining their conditions of service¹⁴. Individual (and usually relatively isolated) GPs had been ineffective in resisting the terms that were suggested by the Friendly Societies and collectives. GPs may have been more powerful if they had been willing to act collectively, but their attachment to individual autonomy was such that they would not consider such an option (Honigsbaum, 1979).

The NHI Act, however, offered considerable protection and security for GPs, as well as a 'keystone' position for them in the new system. Initially, however, GPs raised

influence how *The New NHS* is received and implemented. It is limited to 'English' general practice, as events sometimes differ in other parts of Britain.

¹³ Inclusion in the system was dependant on employment status.

considerable objections to the Act's proposals. This opposition has been attributed to fears that state involvement would limit the scope for more traditional, 'private' arrangements. The resistance was such that the British Medical Association (BMA) succeeded in delaying workers' dependents from receiving coverage (Fry, 1988). The BMA were also able to defend patients' right to choose their own doctor, who would be paid on a capitation basis¹⁵. The capitation method of payment was presented as a way of protecting GPs from being reduced to the status of mere salaried state employees. It permitted distinct relationships between client and professional to remain¹⁶. The efficacy of GP resistance to the new system was however, relatively short-lived; by 1938, the NHI Act covered 43% of the population, and 90% of GPs were working as NHI doctors (Webster, 1988).

The first half of the twentieth century can be seen as a continuing advance of the British state's involvement in health care provision. State involvement in the *provision* of care (beyond simply monitoring external provision) was established through the NHI Act, and was expanded until the eventual creation of the NHS. The creation of a national system of facilities for health care provision has its origins in the nationalisation of hospitals during World War II. Until the war, hospitals had been local institutions, and there was little (or no) coordination of services. The nationalisation of hospitals was embarked upon during wartime with the expressed intention of making the most efficient use of available resources. This original nationalisation programme did not directly affect GPs, except in that it served as a

¹⁴ Previously, many GPs had depended on such organisations to purchase their services, thus rendering GPs in relatively powerless positions.

¹⁵ A capitation system is one in which a practitioner is given an amount of money (usually per annum) to provide specified services for each individual.

¹⁶ An issue that has remained pertinent throughout general practice's history.

pilot for the eventual formation of the NHS, and as such demonstrated that a national network of health care providers was feasible.

The notion of a nationalised health care system was extended during the wartime period, and 1942 saw the release of the Beveridge Report. This report recommended that Britain establish a comprehensive health service free at the point of delivery. The report advocated that the system be staffed by doctors and nurses who would be state employees, and would be organised in a similar manner to civil servants. There was, however, strong GP opposition to ideas proposed in the Beveridge Report – particularly the suggestion that doctors should become salaried employees of the state. GPs were particularly resistant to the idea of group practices. Such organisational structures were not in line with notions of ‘professionalism’, but were rather seen to ‘smack of trade’ (Eckstein, 1958). The strength of GP resistance to such measures was apparent in the modifications made to the ideas within the Beveridge report as it was later applied to the creation of the NHS Act.

In 1946, the Government incorporated the recommendations of the Beveridge Report into The National Health Service (NHS) Act. The Act established the NHS, which would provide comprehensive health care for all that was free at the point of delivery. The system was to be organized around existing structures whereby care was delivered by and through GPs, who would also act as gatekeepers to secondary care. In the newly created NHS, GPs would continue to treat their defined patient

population for the majority of illnesses, and refer the remaining patients to specialist, hospital doctors¹⁷.

The proposed NHS structure received strong GP resistance. Klein (1995) contends that GPs' opposition was largely based on a fear that their professional status would collapse under the new system, and that GPs would simply become state bureaucrats. The sociological literature suggests that such a fear was not necessarily unfounded; GPs may not have been misguided in their opposition to the creation of a 'monopsonistic'¹⁸ system. Hughes states that (1971: 383) "*When there is but one client, it becomes in fact an employer.*" Johnson (1972: 36) also proposes that "*Where, for example, a physician or architect is subject to the whims of a single powerful patron as the sole client; where the client has the power to define his own needs and the manner in which they are to be met, then the relationships of affective neutrality and authority which Parsons claims are inherent in the professional role will be undermined.*" The creation of a single, powerful state provider may indeed have proved quite challenging to the professional claim of general practice.

GPs' opposition to the NHS Act was not, however, particularly effective in preventing the operationalisation of the initiatives – and thus, in 1948, the NHS was born. GP resistance to the NHS proposals had been largely focused around the issues of salaried service and large-scale health centres. To this extent, the GPs were quite successful. These issues were significantly modified between 1946 and 1948 (Honigsbaum, 1979), such that when the NHS was introduced they were no longer key factors in the

¹⁷ This system had been established in the nineteenth century to avoid competition between generalist and specialist doctors (Stevens, 1966), and actually favoured the specialists, who were allocated the more prestigious work (McWhinney: 1967, Jeffreys and Sachs: 1983).

shaping of the system. By acquiescing to these desired modifications, policy makers were successful in gaining the assent of the majority of the profession. By 'The Appointed Day' (when the NHS officially came into being) on July 5th 1948, 86% of GPs had agreed to join the new service, even though many had repeatedly stated that they would resist incorporation..

In hindsight, we can see that the creation of the NHS did have some negative ramifications for general practitioners - GPs' exclusion from hospital practice being one pertinent example (Webster, 1988). In the early days of the NHS, GPs focused their efforts on resisting increased municipal control and salaried service. Thus, the issue of general practitioners' exclusion from hospital practice was largely ignored (Honigsbaum, 1979). GPs' exclusion from hospital practice was, however, quite significant because it meant that GPs were kept distant from many of the technological advances that would become key to the progression of medical power (Fry, 1988). Fry (1988) claims that GPs' exclusion from hospital practice was by no means incidental, but was rather part of a 'deal' struck between Bevan (the Minister for Health at the time of the NHS' formation) and medical specialists in order to gain their support for the new system. GPs' exclusion from hospitals served to strengthen the boundary around specialists' professional mandate.

The formation of the NHS did not, however, seem to have a great impact upon the daily practice of GPs, nor the experience of the patients who were seeking treatment (Stevens, 1966). Whereas the creation of the NHS may have profoundly altered the foundations of the service, it did so without challenging the status quo of GPs' daily

¹⁸ With one dominant client/purchaser

routine. Indeed, the continuation of ‘the way things were’ may have facilitated an easier transition into the NHS for both patients and GPs. It also seems, however, to have allowed many of the system’s weaknesses and needs to be overlooked. In some cases, very poor working conditions and practices were allowed to continue or even worsen (Collings, 1950)¹⁹. Calnan and Gabe (1991) attribute the lack of attention given to general practice during the NHS’ formative years to the power differential between GPs and their specialist colleagues. During this period, ministers focused on placating the powerful hospital doctors, such that the needs of general practice were largely ignored.

The years following the formation of the NHS have sometimes been defined as times of professional discontent, and conflict with the government. During the first two decades of the NHS, levels of medical emigration were very high, and the number of newly qualified doctors choosing to enter general practice was in decline (Fry, 1988). Pay was also a central issue for government/professional relations during this period (the 1950s and 1960s), such that in 1952, the Danckwerts Report recommended a 100% pay rise for all GPs. Relations between the government and GPs were not improved by the government’s refusal to implement this recommendation.

Professional dissatisfaction reached such a level in 1955 as to warrant an independent commission was established to consider increasing doctors’ and dentists’ remuneration (Fry, 1988). This commission was not, however, successful in

¹⁹ In 1950, the very influential Collings Report was published in *The Lancet*. The author of the report (Dr. Collings) was a visiting GP from Australia who surveyed British general practice in the years immediately following the formation of the NHS. His report was highly critical towards the then current state of general practice. The Report is said to have been an important contributory factor for GPs’ low morale and discontent over conditions that grew over the 1950s and 1960s.

appeasing the profession, and support grew in favour of a national strike, or other such measures²⁰. This 'fallow' period can be interpreted as having had some positive consequences for the development of the GP profession. Fry (1988) maintains that although this period was defined by grievances, it was here that GPs learned of the power that they yielded when they acted as a homogeneous entity²¹.

The College of General Practitioners was established in 1952 with the expressed intention of addressing some of the difficult issues facing general practice within the NHS. Although morale among GPs, and the relationship with specialist colleagues were both so strained that the College initially be founded in secret (Waine, 1991). The College was charged with working for the professional development and recognition of general practitioners and the official goal of the organisation was to "encourage, foster and maintain the highest possible standards of general medical practice" (Royal College of General Practitioners, 1996). The formation of a professional College was intended to protect the interests of general practitioners in the same way that it had for specialist doctors - to provide a professional network, and would support the development of education in the area of general practice. The role played by the existence of a college for the status of a profession was seen to be very important.

²⁰ Talk of a strike culminated in 1965, but such action was never operationalised.

²¹ Although relations between the government and general practitioners were strained during the formative years of the NHS, and general practice was facing very low member morale, the profession was spared from having to adjust to major organisational reforms. Hospital medicine (rather than general practice) tended to be the focus of such initiatives, rather than general practice. With the cost of the NHS expanding far beyond initial expectations, policy makers were charged with bringing costs down. As hospitals were perceived as being the most expensive component of the system, they were targeted in efficiency drives and cost control measures (Allsop, 1995).

The College was ultimately very successful; within six months there were over two thousand members (Stevens: 1966). The College was granted a Royal Charter²² in 1967, and became the Royal College of General Practitioners . Further professional development came in 1968, when a Royal Commission officially recognised general practice as a distinct medical speciality, with its own educational and training needs. Before this time, specialist doctors had been assumed to have had all of the skills and knowledge of GPs, in addition to their own specialist knowledge. Recognition from the Royal Commission, and the development of the Royal College of General Practitioners were important factors in bolstering the status of the GP profession.

2.5.1.1 General practice and NHS ‘reform initiatives’

As I have already noted, general practice was overlooked in most, but not all, early reform initiatives. It was not until The Family Doctors Charter (1966) that GPs found themselves in the spotlight of reform efforts.

The Family Doctors Charter was founded on a growing belief that many of the conditions of general practice (single-handed practice, twenty four hour coverage and antiquated premises) were unsupportable in the long term. The Charter introduced a basic practice allowance as the foundation of GP remuneration (Fry, 1988). It also set out support mechanisms for the development of group practices, and enhanced ancillary support services. The initiative received some professional resistance on the basis that it reflected government’s intentions to more directly influence GPs’ practice (Irvine and Jeffreys, 1971). The Charter was, however, effective in changing the

²² A sign of significant recognition.

working practices of many GPs, and led to a reduction in the number of single-handed practices, as well as less home visiting, and increased use of deputising services (Cartwright and Anderson, 1981).

It has only been since the mid-1980s, however, that reform efforts have focused on general practice to any great extent (Calnan and Gabe, 1991). The gradual shift away from initiatives focusing on hospital medicine might be partly accounted for by a global trend towards prioritising 'primary care' as being central to the success of service systems, as exemplified in the World Health Organisation's Alma Ata declaration in 1978.

By the late 1980s and early 1990s, a 'managerial' or 'business' ideology had begun to permeate the ideology surrounding British health care (Clarke, Cochrane and McLaughlin, 1994), and general practice was identified as an area to which such ideas might be fruitfully applied. The incorporation of managerial principles to general practice involved introducing contracting and marketing skills, as well as financial management and performance assessment systems to a realm where such notions had not previously mattered a great deal. Day and Klein (1986) predicted that such changes would force general practitioners to rethink their attachment to independent contractor status. Both the increasing centrality of primary care, and the attention given to accountability could be interpreted as potential threats for GPs' autonomy.

In 1984, a controversial initiative was introduced in the form of a limited-list of prescriptive medicines paid for by the NHS. The limited-list initiative was aimed at controlling prescribing costs by identifying a defined set of drugs and treatments

supplied through the NHS. A treatment's inclusion on the list was said to be based upon standardised effectiveness criteria. This initiative was aimed at both hospital doctors and GPs. It met with enormous resistance from both the BMA and the pharmaceutical industry, who argued that the government did not have the necessary expertise to make such decisions. Ultimately this opposition resulted in government retreat, and only very minor prescribing restrictions were maintained (Webster, 1998). It is however, still an important measure in the development of ideas as to the appropriate level of government involvement in clinical decision making.

The 1990 GP Contract was another relatively contentious reform initiative focused on general practice. The contract was seen as directly affecting GPs' daily practice by increasing the emphasis that was placed on the 'preventative' aspect of GPs' work in the payment system. The stated objective of the contract were to reward 'high-quality services', and to ensure greater efficiency and consumer satisfaction (Webster, 1998: p. 41). The contract increased the importance of capitation as a means of payment for GPs, and introduced a more consumerist philosophy to general practice²³. The GP Contract outlined how patients were to be provided with greater levels of information about practices, and to be encouraged to take a more active role in choosing their doctor²⁴. Furthermore, the 1990 reforms set targets for immunisation and screening programmes; GPs' whose practices met the targets would receive incentive payments (Langley, 1996).

²³ A philosophy that was greatly extended with the introduction of The Patients' Charter in 1992.

²⁴ Although it was never clear that the structures necessarily to facilitate such a choice being a reality were put into place.

1990 was a highly significant year for general practitioners. Not only did the reforms indicate that their roles should shift towards consumer focused, preventative medicine with the introduction of the GP Contract, but market principles were also introduced into British health care through the *NHS and Community Care Act* (1990). The rationale for the structural overhaul proposed in the NHS and Community Care Act was that the NHS' bureaucratic organisation was inefficient, and the system could be greatly improved by introducing elements of competition. Thus, 'the internal market' was established within the NHS, and a formal division between the purchasers (the health authorities and the newly created 'fundholding' GPs) and the providers of care (namely hospitals) was created. The transactions between these newly separate entities were to model 'real world' market relations, with both 'sides' now having distinct goals and purposes. The extent to which this actually occurred is, however, questionable.

In 1991, hospitals became self-governing 'Trusts' modelled on the private sector, and larger GP practices were given the option of taking control for purchasing specified areas of care for their patients (known as 'fundholding'). The policy rhetoric stated that such purchasers of care (Trusts and fundholders) would be responsible for adhering to a budget, and for using available resources to attain the best possible care for their patients. Furthermore, traditional localised care relations were challenged, and purchasers were officially encouraged to 'shop around'²⁵. Webster (1998) notes that there was intense opposition to this reorganisation from the medical profession,

²⁵ Research, however, suggests that such 'shopping around' did not occur (Hughes and Griffiths, 1999). Traditional providers often provided the most (or only) practical option for patients. Even where these providers were under-performing, NHS managers were usually reluctant to remove contracts to the extent that they became economically unviable. The pattern of behaviour seemed to be that traditional care relationships were maintained, and contracts were moulded around local capacities.

and that such opposition was largely ignored. The government forged ahead with little professional consultation.

Fundholding was introduced on a voluntary basis, and with each passing year more GPs became 'eligible' for inclusion within the scheme (the government continually reduced the minimum practice size). Initially there was a relatively widespread professional rejection of such managerial measures. GPs tended to conceptualise the new tasks as being out of line with their professional role (Greenfield and Nayek, 1996). Although initial GP opposition to fundholding was fierce, involvement in the scheme became perceived as a way of gaining greater access to resources. By 1996, nearly forty percent of the population were registered with a fundholding GP (Kendall et al: 1996).

Viewed in hindsight, the internal market is often dismissed as a failure – creating more inefficiencies than those with which it dealt. The notion of market based initiatives as a means of improving efficiency and effectiveness within health care systems has, however, gained credence both in the UK and in other countries (not least in the US, which served as a 'test-bed ' for such ideas).

Light (1999c) proposes several reasons why a market-based system of health care provision may have gained popularity among policy makers- even once such a system was shown to be ineffective. His analysis goes back to the international oil crisis of 1973 that slowed down economic growth throughout the next decade. During this period, in order to keep levels of health care provision steady, countries were forced to increase the proportion of GDP (Gross Domestic Product) that they spent on such

services²⁶. In Britain, the incremental expansion of the NHS was suddenly halted.

Light suggests that the medical profession was an important contributory factor in the increasing costs of health care, and that these costs were central to the growing public criticism of this health care system. The cost pressures interacted with a worldwide paradigm shift towards a perception of the state as inefficient, incompetent and inflexible, as well as in need of competition, deregulation and privatisation. The combination of these factors created the conditions in which 'market based' reform measures could be developed and introduced without fervent public opposition.

2.5.2 Summary

"It has been the autonomy of doctors locally rather than the power of the British Medical Association which has blunted the drive for change." (Harrison et al. 1992: 2)

Events in the history of English general practice have shaped the form of the contemporary profession. It is also the case however, that for each initiative introduced, the profession's reaction to the proposals has shaped policy implementation. Scott (1982: 236) contends that *"Few attempts at rationalization and reform have considered how practitioners may be expected to interpret and react to administrative goals or 'the specific mechanisms by which policy goals are to be reached. It is also the case that administrative controls developed thus far (both incentives and sanctions), have not been powerful enough to cause major behavioural changes in practitioners who have their own ideologies and justifications for care decisions"*. GPs' professional position has frequently enabled them to resist measures that were not seen as in keeping with their own occupational agenda.

²⁶ Webster (1988) concurs that the onset of the global oil crisis in the middle of the 1970s was very

The history of general practice has shaped (and continues to shape) the profession's reaction to, and power over, reform initiatives that are introduced. Hanlon's (1999) research on the English solicitor profession raised several issues that are salient to this consideration of the history of general practice. Hanlon claimed that the history of the solicitor profession has been shaped by solicitors' perception that they have an inferior status to their barrister colleagues. This perception has, in turn, induced solicitors to focus more on the pursuit of wealth and respectability than might otherwise have been expected. Comparisons can be easily made as to the influence of the differential status between general practitioners and their consultant colleagues in determining the path that general practice would follow.

Lipsky's (1980) notion of 'street level bureaucrats' may also be helpful in considering the extent to which local professionals (who are charged with implementing policy initiatives, and have a wide discretion over the dispensation of resources and services) play a role in determining the course that policy will actually run. Local professionals (such as GPs) are frequently charged with operationalising centrally instigated policy. These local actors are powerful enough to do so in a discretionary (rather than blindly obedient) manner. This discretion contributes to their local influence, thus making them important partners in proposed initiatives, but also serves to complicate the implementation of such measures. Local professionals are key actors in determining the effectiveness of such policies, or at least the extent to which policy is put into place as officially outlined.

The centrality of influential local actors (increasingly understood as ‘professionals’) for the successful implementation of policy initiatives necessitates a careful consideration of their role in the process. Dopson (1996) claims that “*Relatively little work has been done exploring the doctors’ role in the management of health services, and even less work has been done exploring the implication of recent moves to involve doctors more closely in the management process,*” (p. 173). Dopson (1996: 185) also maintains that the work that has been done in this area has largely been empirical, with very little theoretical foundation. My study seeks, at least in part, to address this shortfall.

The history of the NHS suggests that general practice is central to the effective implementation of reform initiatives. The history of English general practice, however, also suggests that this group is unlikely to assume an ‘obedient’ position in relation to any proposed changes. An analysis of the role of general practice in implementing reform initiatives that is informed by their professional history has the potential to make an important contribution to the existing literature. This thesis takes the 1997 White Paper, *The New NHS: modern, dependable*, as an opportunity to conduct a ‘case study’ of this important interaction, and to learn more about both the development of the GP profession and the local implementation of policy reform.

2.6 “The New NHS”: The Labour government’s promise of ‘real’ change

The White Paper, *The New NHS: modern dependable*, was released in December 1997. It was the product of the newly elected Labour Government’s election promise to dismantle the internal market and reform the NHS. The *new* NHS would

incorporate the efficiency measures of the market based system, but would be based on collaboration, rather than competition.

Many of the reforms outlined in the White Paper centred on general practice. The Labour Party had adopted an oppositional position towards fundholding, and had promised (if elected) to dismantle the “two-tiered” service that this created. Concern was expressed that patients of fundholding doctors were receiving better/speedier hospital treatment than patients whose doctors’ budgets continued to be controlled by health authorities. Fundholding GPs had been given the power (at least theoretically) to cancel contracts if they were dissatisfied with conditions or care being offered by a particular Trust, and to send patients to other providers. Health authorities were seen as having much less flexibility.

The New NHS outlined the structures that would replace fundholding. The policy did not propose to re-institute pre-fundholding institutions, but rather to introduce new organisational structures. Newly formed Primary Care Groups (PCGs) would be at the heart of the new system. The internal market would be disbanded, but the distinction between purchasers and providers of care would be retained. PCGs would incorporate the GPs and other ‘stakeholders’²⁷ working in and for a local population of approximately 100,000 patients. PCGs would be led by local professionals, through whom all resources for patient care would be channelled. These new local structures would be charged with the work of resource allocation for their community.

Controversially, unlike the fundholding initiative that it replaced, *The New NHS*

²⁷ Such as nurses, practice managers, social services representatives and voluntary sector representatives. The remit was expanded beyond traditional ‘health’ boundaries.

would not be based upon voluntary professional participation; all GPs working within the NHS would be required to become members of a PCG.

The New NHS outlined a progressive transition to increasingly autonomous primary care institutions. Initially, all Primary Care Groups would have the status of subcommittees of the Health Authority (Level One). However, over time, it was expected that all PCGs would apply for more control, which would be granted in increments (Levels two, three and four). Ultimately, Primary Care Groups would become Primary Care Trusts that were independent of any health authority (and indeed, actually subsumed its authority), and totally responsible for the provision of care for the local community.

There was (perhaps not surprisingly) considerable professional opposition to the proposals outlined in *The New NHS*. A particular fear was expressed that the proposed changes threatened the independent contractor status of GPs, and that ‘collectivising’ GPs into PCGs would bring about an end to the traditional practice structure. This opposition was forcefully demonstrated (and perhaps developed) through the professional press. The British Medical Journal (BMJ) was influential outlet for the debate of the potential challenges - “*Despite the protective conditions negotiated by the General Practitioners Committee in June 1998, the introduction of co-operative working, clinical governance and unified budgets could render independent contractor status unsustainable.*” (Roger Chapman, BMJ 318: 797-798 – March 20, 1999). Discussions between GPs as to the possible effects of the changes for the profession were also occurring within more informal professional networks. I followed the dialogue occurring between a group of GPs on a national electronic mailing list for eighteen months (Clegg, 1999), and the consequences of the reforms

for professional autonomy was a prevalent and recurring topic of discussion – particularly around the time that *The New NHS* was released.

Although *The New NHS* certainly posed challenges for general practice (that will be considered in the following chapters), not everyone agrees that the reform initiatives necessarily signal a bleak future for general practice (Griffiths and Hughes, 1999).

Examinations of the micro-level interface between managers and medicine are necessary in order to provide the empirical evidence to test different positions. There are, however, relatively few studies that have given detailed consideration to local negotiations between managers and professionals that result in new institutionalised patterns of working. Griffiths and Hughes (1999) contend that it is through such micro-interaction that change is brought about – rather than being imposed externally from above.

This study focuses on just such local negotiations. It is concerned with the way that policy rhetoric is implemented locally, particularly the role played by the GP profession. I examine what policy actually becomes when it is operationalised, and how we can best understand this process.

3. Methodology and the Research Process: Exploring the translation of official policy into workable action: The case of The New NHS

3.1 Introduction

In this chapter, I will present and discuss the decisions that I made with regards to collecting and analysing data. In so doing, I will address the following questions - How did I collect my data? Why did I choose to conduct the research this way? What are the strengths (and potential weaknesses) associated with my decisions? How did I apply the data collected?

The fieldwork for this research took the form of an in-depth, longitudinal ethnographic case-study. I conducted research within one health authority (the I gave the pseudonym 'Casterdale'). The fieldwork consisted primarily of participant observation of commissioning meetings and preparatory work for the introduction of the new PCGs, and in-depth interviews with participants in these processes. I analysed official documentation about the change process that was produced by health authority, the NHS Executive and the Department of Health. Finally, I conducted a few key observations and interviews outside of the health authority, and followed discussion occurring on a national electronic 'mailing list' for GPs over an eighteen month period²⁸.

3.2 'The New NHS' as a catalyst

Hammersley and Atkinson (1995) note that social research is often precipitated by the occurrence of a particular event or events. The conditions during times of change or upheaval may offer opportunities to explore unusual occurrences; social phenomena that are usually taken for granted may become problematised. Studying periods of change can offer insight into important aspects of social interaction.

In my research, I took the release of the White Paper, *The New NHS*, to be such a catalytic event. The announcement of this NHS 'reform' initiative in December 1997 provided an opportunity to follow a major programme of structural and ideological change. I anticipated that this period of transition (and potential challenge to the professional power of general practice) would stimulate a demonstration by GPs of certain factors seen as being key to their claim to professional authority. Thus, this reform provided a potential opportunity for an explicit consideration of existing theories regarding general practice's professional foundations. It also facilitated an analysis of the role played by professionals (particularly GPs) in shaping the implementation of policy implementation.

The fieldwork was conducted over eighteen months following the release of the White Paper, *The New NHS* in which the newly elected Labour Government's organisational plans for the health service were outlined. I focused on the potential effects of the reform initiatives on the involvement of general practitioners in managerial work, and on the role of GPs in the implementation of reform measures. My research was, however, entirely conducted before the announcement of a subsequent set of major

²⁸ These data were excluded from the present analysis, but served as important background information for this study. For further discussion of the Email data see Clegg (1999).

organisational reform initiatives for the NHS in 2000, thus, the analysis presented in this thesis is limited to the 1997/8 reforms.

3.3 Methodology

Ethnographic research can often accommodate complexity in a way in which quantitative methods that rely on reductionist analytic techniques are rarely able (Murphy et al, 1998). I chose an ethnographic approach because this allowed me to embrace the complexity of the social setting, rather than requiring a reduction or simplification of the interaction for the purposes of research and analysis. My methodology was further shaped by the premise that previous research on NHS reform has soemtimes been limited by the analytic tendency to oversimplify the processes of change and reform implementation.

Ethnography is particularly suited to my research objectives because of its utility in relation to relatively new or under-researched domains. This approach allows the researcher to expand understanding by taking small, relatively uncharted steps into unexplored realms. For ethnographic research, detailed knowledge about how the research might unfold is not a pre-condition. Both the methods and the philosophical underpinnings of ethnography provide room for the development of theory throughout the research process. Jorgensen (1989) describes participant observation (a key ethnographic tool) as a process aimed at instigating concepts, generalisations and theories. Ethnographic methods allow the researcher more flexibility in relation to research plans, and incorporate the idea of the researcher continually reflecting upon their expanding understanding of the particular social object under study. These methods allow the exploration and incorporation of developing perspectives of the

social world, alongside the process of data collection. The ‘emergent’ nature of an ethnographic analytic framework also allows more scope for ‘negative cases’ to be incorporated into analysis (Silverman, 1989).

Atkinson (1979, in Murphy et al, 1998) suggested that early social research tended to take a ‘black box’ approach to understanding social phenomenon, focusing on ‘causes’ and ‘outcomes’ without being overly concerned with how one leads to the other. Ethnographic methods are particularly appropriate when one’s research is focused on ‘processes’ and/or change (Finch, 1986). My research focuses on the implementation and incorporation of a set of government reform initiatives by GPs and managers within one health authority district. Conducting a mixture of participant observation and semi-structured interviews enabled me to both observe action and gather reports of this action. The longitudinal element of the case study provided the opportunity to observe the process of the reform implementation, particularly focusing upon the incorporation of change and the development of local manifestations of reform.

3.3.1 Ethnographic data: personal perspectives or public accounts?

Qualitative research is sometimes presented as facilitating the researcher in ‘getting inside’ the object of study. This model of qualitative research prioritises a ‘raw’ application of the categories and meanings used by the participants themselves with the goal of understanding participants’ perspectives (Bryman, 1988). Thus, any imposition of external categories or theoretical structures by the researcher is seen as invalid. Advocates of this position assume that ethnographic methods allow

researchers to become intimate with the intricacies of how things *really* are. In turn, researchers are seen as being able to access the ‘backstage’ of social action, appreciating what people *actually* think and feel, and thus *properly* explaining why people act in the way that they do.

Prior (2000) states that such an objective for sociological research is essentially futile, because researchers who intend their work to uncover people’s knowledge or beliefs set themselves the difficult (nay impossible) task of accessing inner psychological states (p. 195). Such research necessarily faces the inability (or unwillingness) of participants to share this information with the researcher, and of the researcher to both adequately understand and incorporate any information into analysis.

Qualitative social research can also be seen as a process through which one seeks to identify and interpret the *accounts* for action that are purposefully produced by actors. Accounts do not require access to inner thoughts or beliefs, but are rather publicly produced, and thus available (Prior, 2000: 195). Accounts are valuable largely *because of* their social manifestation. Prior draws upon Gerth and Mills’ (1953) concept of ‘motive’ to further explicate the usefulness of accounts for social research. When called upon to produce an account for one’s actions, or one’s perspectives of a particular phenomenon, a collective culture of socially acceptable positions, justifications and rationales are likely to be engaged.

Thus, research that focuses on what people say and do (in public situations) can be a study of what is understood to be socially acceptable and appropriate – given people’s perspective and agenda in any given situation. The objective is to identify, and to

seek to understand the many different presentations of participants in relation to everyday interaction. Such analysis supports the possibility of numerous, non-competing accounts, rather than a hierarchy of competing descriptions. Furthermore, the accounts are then applied as ‘gateways’ to further understanding the social processes that shape the phenomena of interest (Silverman, 1993). The purpose is not to simply recount particular actors’ perspectives, but to apply these to understanding social action (Hammersley, 1992b). My position in embarking on this research was more aligned with the ‘accounts’ approach, rather than that of ‘researcher as insider’.

3.3.2 Accounts from Casterdale

I gathered various accounts of the policy implementation process from different ‘types’ of participants, in different settings, and at different times. I interviewed actors engaged in the change process, as well as (wherever possible) observing the mechanisms through which the structures relevant to realisation of *The New NHS* were being shaped at the local level. The data consisted of different types of accounts, as well as different perspectives of the reform process; accounts of the change process given in the interviews were quite distinct from those being produced in Health Authority public meetings.

I concentrated my data collection within one health authority district, and treated this as a single ‘organisation’ for the purposes of the research. My ethnographic approach facilitated an in-depth exploration of interaction within a particular setting. I sought to forge new understandings and interpretations that could subsequently be applied to different social phenomena, based upon the identification of similar underlying structures and processes. My analysis was, however, necessarily both driven and

contained by the particular fieldwork context, as well as my pre-existing theoretical beliefs, and my research interests.

Hammersley (1992) describes the purpose of ethnography (in terms of generalisability) as being to locate the general within the particular. ‘Unique’ social occurrences and events are actually often the manifestations of common, underlying social structures. Ethnographers’ intention need not therefore necessarily be to conduct research on a population or setting that is ‘typical’ in some way. Small pieces of research in diverse settings may provide valuable insight into social processes beyond the particular confines of the empirical event, population or institution that may have been studied. Ethnographic researchers may therefore choose to abandon the goal of simple ‘empirical generalisability’ in favour of producing more ‘theoretical’ generalisations (see section 3.4.2 for a fuller discussion).

I sought to examine the processes occurring within a particular Health Authority district after the release of the reform initiative, *The New NHS*. In particular, I focused upon the transformation of existing local structures into those mandated by the White Paper, and the development of GP involvement in managerial roles and resource allocation decisions. My choice of research setting was intended to contribute to sociological debates on policy implementation, and on the development of the professional claim of English GPs.

3.4 The Research Process – Studying the implementation of policy at the local level

For qualitative researchers, the development of one's research design is an important element of one's report of research findings (Creswell, 1994). The researcher may begin the fieldwork process without precise knowledge of the methods that they will use, the means by which such decisions were made are therefore important to any discussion and evaluation of the research process.

In the following sections, I will document the decisions that I made about conducting my fieldwork. I will begin with my decision to carry out a single case study in one health authority district. Then, because some 'background' information about the setting is important, I will outline how I chose the particular setting. I will provide details as to the relevant organisational structures that were in existence when I began my research, and those that developed during the fieldwork period. This should allow the reader to engage with the analysis and discussion that make up the following three data chapters. These details are also important in order to assess the relevance, validity, and potential application of my research.

3.4.1 Casterdale Health Authority

I chose a single 'health authority district'²⁹ as the setting for this research because of the organisational importance of such structures within the NHS; it incorporates both managerial and clinical elements. The health authority is a particularly important structure because its members are charged with the implementation of many of the decisions and actions relating to centrally initiated reforms. Conducting research at this level, therefore, offers unique opportunities to observe a key interface between

abstract reform ideas and their practical implementation. Once I made the decision to focus on one health authority, I set out to learn more about these structures in order to identify one that I might approach regarding access. I quickly learned that health authorities are quite heterogeneous institutions; seemingly shaped as much by local conditions as by national policies.

I chose to approach a health authority that was widely identified as being at the forefront of developments in general practice³⁰. This district had a history of relatively successful, locally formulated collaboration between local GPs and health authority managers, and GPs were already voluntarily involved in both managerial work and resource allocation. Furthermore, a local, collaborative structure (The Commissioning Group or TCG) had been developed between GPs and Health Authority managers as an alternative to the Conservative government's fundholding initiative³¹. GPs and managers in this area had typically been opposed to fundholding (which had been identified by the new Labour Government as 'on the way out'), and GPs in this district had been actively involved in the formulation of alternative structures.

²⁹ Milewa, Valentine and Calnan (1999) use the term 'health authority district' to define their research focus. I take it to incorporate all those who provide health care for the NHS within the geographical bounds of the health authority, not being limited to those who work directly for the health authority.

³⁰ I am careful with the level of description that I provide with regards to the health authority, as such description could make the setting easily identifiable (see the later section on Ethics).

³¹ The TCG consisted of over two hundred local GPs. It was managed by a 'Forum' of sixteen GPs elected by the general TCG members. The Forum met once a month. In addition, four GPs were elected from among the Forum members to serve on the TCG project board with members of the Health Authority. The TCG Project Board had the authority to make and uphold decisions, whereas the Forum was merely advisory. Each of the Forum GPs sat on one of four 'Programme of Care' Committees with members of the Health Authority and representatives from the secondary and tertiary sectors. These committees were responsible for making commissioning decisions. With the establishment of PCGs, the TCG Forum 'morphed' into the Collaborative Commissioning Mechanism. The PCG Chairs Committee seemed set to take on many of the responsibilities previously held by the TCG Project Board. Throughout the fieldwork, the Health Authority held a monthly Board meeting at which all decisions were formally presented and approved. This is a public meeting, but with considerable (and seemingly non-negotiable) closed sessions.

Pre-existing GP involvement in commissioning³² tasks made the research setting quite distinctive in terms of its organisational structure. The TCG was central to the Health Authority's commissioning of secondary services. The TCG consisted primarily of a 'Forum' of GPs, who were elected by their local GP colleagues. Their role involved meeting regularly to make collective commissioning decisions, as well as serving as GP representation on an array of Health Authority resource allocation committees (known locally as the 'Programmes of Care'). Conducting fieldwork within this setting at this particular time allowed me to observe the change process from voluntary GP involvement in a single, locally-formulated voluntary³³ system (the TCG), to the implementation of mandatory professional membership of several government-initiated organisations (PCGs).

My choice of health authority was partially pragmatic, because unlike other areas, Casterdale had pre-existing structures to which I could seek access. This allowed me to follow the implementation process, rather than to simply reflect upon it once the new structures were in place. If I had chosen a health authority where GPs had little history of participation in management decisions. I would have had to wait for structures to be established before I could have even sought access to embark on fieldwork. Once I had chosen Casterdale Health Authority as an appropriate 'case study', I sought to identify accessible settings where GPs were involved in tasks that had traditionally fallen to the Health Authority.

³² 'Commissioning' was an idea formulated in response to objections to the contracting process that developed with the creation of the internal market in the NHS after *Working for Patients* (1990). Commissioning essentially retained the separation of the providers and purchasers of care, but sought to replace the philosophy of competition with that of co-operation.

³³ GPs did not have to be actively involved, or even join, the TCG.

3.4.2 Generalisability

Hammersley (1992) stated that it is rare for the findings of ethnographic research to be intrinsically relevant beyond the particular setting (p. 85). It is however, important that all research is sometimes applicable beyond the interests of the individual researcher, and in relation to the particular population. Generalisation need not, however, necessarily entail a straightforward application of substantive findings from one setting to another. 'Straightforward' applications based upon substantive similarities between 'cases' are referred to as *Empirical* generalisations. In such instances, a case or setting is chosen because it is deemed to be 'typical' of a population (such as a 'typical' British firm, or a 'typical' university), with the expectation that findings will be directly generalisable to the larger population.

It is often the case, however, that one has limited knowledge of the larger population, and that typicality would be difficult to determine, or of little relevance. In such instances, it may be more appropriate to seek to generalise on a more abstract, theoretical level. Where one focuses on social processes, rather than on specific circumstances or outcomes then one is particularly unlikely to be concerned as to whether a site is either representative or typical (Burgess, 1984). *Theoretical* generalisations focus on underlying structures and processes that are deemed to shape the action and events in a particular setting. Analysis of structures and processes in one setting can be applied to others that may, on the surface level, seem very different. In such instances, both pragmatic sampling matters (such as the ease of access or people's willingness to participate), and theoretical considerations (the underlying structures that different processes may share) take a more central role in sampling decisions.

In outlining my research setting, I will indicate ways in which the findings are generalisable on a *theoretical* level. The Health Authority tended to present itself as innovative, and the GPs had a history of political involvement at both the local and national level. For instance, the health authority that I chose was both ‘distinctive’ as well as ‘typical’. The heavy involvement of Casterdale GPs in commissioning work before the publication of *The New NHS* is quite a unique factor in the local implementation of the reform initiative in Casterdale. When I began my fieldwork, both GPs and managers described Casterdale as being a ‘flagship’ for *The New NHS* initiative, although GPs would later describe feeling betrayed by the structures that were actually implemented.

The exact reform implementation procedures in Casterdale, and the development of the relationship between GPs and the Health Authority both before and after April 1st 1999 (the date at which PCGs went ‘live’), are therefore unlikely to have been precisely replicated in any other location. I found little evidence of an active communication network between health authorities, and participants described the implementation of *The New NHS* as being less prescriptive than previous measures, prioritising local interpretations and applications rather than national synthesis. From first observations, it appeared as if relationships between health authorities grew in isolation, dependant on local conditions. It would therefore follow that the idea of a unique change process, whereby health authorities felt as if they were ‘flying by the seats of their pants’ might actually have been common to many settings. The felt *individuality* of my setting might also be a *typical* characteristic of health authorities during periods of upheaval.

(See Appendices 3iii and 3iv for structural diagrams and accompanying descriptions of Casterdale Health Authority at the beginning and at the completion of the fieldwork.)

3.4.3 Access

In their reports, researchers frequently acknowledge the process of gaining access to research settings and participants, but seldom go further than to ‘skim over’ the process. In the following section I will provide a relatively detailed outline of my access process, with the intention of providing valuable insight into the research setting itself.

The lack of any single permanent physical setting related to the structures and change processes in which I was interested in following was a particularly pertinent access issue. Neither the TCG (Total Commissioning Group) nor the newly forming PCGs had any physical base or ‘headquarters’ in which I might situate myself. This limitation proved to be significant both in terms of understanding the nature of the interaction that was occurring, and because of the challenge that this posed to my data collection. I found it difficult to keep up with developments, to immerse myself in the organisational culture, to build up a rapport with participants, and to make informal contacts. Rather than learning anything by ‘hanging around’, I constantly had to seek out information through formal, but changing, channels.

Upon starting fieldwork, I had only a limited understanding of the organisational structure of the Health Authority . Although I had researched official policy and established structures, I had found little information about the way that such work is

managed locally. This type of knowledge seemed to be largely tacit. Many of the access challenges that I faced seemed to reflect the politics of the organisation – notably in relation to the complex and hierarchical decision-making structures of the Health Authority committees.

Gaining access is sometimes portrayed as largely a matter of ‘playing it by ear’ and making impromptu decisions regarding tactics (Hornsby-Smith, 1993). Unfortunately, the organisational formality of the Health Authority did not foster spontaneous decision making; I had to formally arrange access to each setting that I wished to observe. I was also unlikely to be made aware of meetings that were occurring without speaking directly to those involved in their organisation. When I did learn of a meeting, I had to follow formal channels for seeking access, or fear alienating the different actors involved in (and perhaps more crucially, in charge of) such structures.

The pace with which the organisation was changing also meant that there were occasions when I was given permission to observe at a particular committee, only to find by the next week that it had been disbanded, restructured or renamed. A week later, the structure would often have a slightly modified membership, and would be under the control of a different Chair. I eventually arranged access to, and conducted observations in thirteen different organisational structures in relation to GP commissioning and the formation of PCGs within this one Health Authority district. There were, however, numerous other structures to which I could not obtain access from an appropriate gatekeeper, or of which I learned only once they had ceased to exist.

During my fieldwork, I often felt like an outsider – vulnerable and out of place. I was frequently the only non-member present in meetings, even when these meetings were officially ‘open’ or ‘public’. I also sometimes felt conspicuous simply because of my physical appearance. Although I sought to ‘fit in’ through appropriate behaviour and dress, I felt that my gender and age made me feel more segregated within this research setting than I might have in others.

My access difficulties may also be somewhat attributed to the unusual social dynamics of the setting in which my research was being conducted. Little meeting time was spent on informal socialising. At the commissioning meetings, GPs tended to arrive in advance of the official start time, and to leave as soon as the meeting was over (often this would be over three hours later – and as late as 10:45 p.m.). At other meetings, the ‘public’ session came between confidential sections – leaving me with no time for observing or engaging in informal conversation. I often felt that the formality of the meetings, and the pressured agendas made it quite difficult for me to get to know the participants – or (perhaps more importantly in terms of access) for them to get to know me.

The complexity of my access process, however, also reflected characteristics that were inherent to the particular setting (rather than to me as a researcher), and had much to do with the reform initiatives and the formation of PCGs. My access difficulties seemed to mirror a perceived shift in the power relationships, particularly the tension within the Health Authority over continued control over managerial tasks. The Health Authority management often seemed wary of imminent confrontation with and between the GPs, and were not particularly keen to have anyone observe this, if it were to unfold.

By the end of my fieldwork, I began to feel less vulnerable. I received more smiles of recognition at the meetings, and more people said 'hello'. Occasionally, people would ask questions about the progress of my research during breaks in the meetings. It was not clear whether this change was due to increasing numbers of GPs having met me individually through interviews, or to members feeling more comfortable about my presence at meetings. The different atmosphere may even have reflected the changing membership of the meetings. Membership was becoming more diverse; nurses, social services representatives and 'lay members' were included on the new PCG boards. It is possible that the newer members saw me as a 'regular feature' within the setting, and were therefore less likely to question my presence.

I made some early mistakes while trying to gain access that shaped the direction of my research. In one instance, a Health Authority middle manager (the Commissioning Co-ordinator) granted permission for me to observe a group of meetings. When I arrived at the first of these meetings, however, I found that the Chief Executive of the Health Authority also sat on the committee, and had not been informed of this decision. The Chief Executive did not support my continued access to these meetings until I outlined my research to him in writing, and we had met to discuss the details of my research in more detail. This spurred a dialogue about my access to numerous such settings

With hindsight, I feel that my access process provided a valuable opportunity to learn about the changes occurring, and their significance for particular actors within the setting. I incorporated this insight into my analysis; the confusion as to who had the authority to grant me permission to observe meetings is one reflection of the struggle

that I observed in relation to authority over the changing and newly forming committees and structures.

3.4.4 An account of the access process

As described, the complexity of the Health Authority's organisational structure made gaining access quite a tricky business. My interest in an organisation in the midst of change necessarily meant that structures were shifting during the research period.

I embarked upon my fieldwork by arranging to informally discuss my research with the GP who chaired the Total Commissioning Group (TCG). I wrote to him outlining my initial research plans, and he agreed to meet me. During this meeting, he granted me permission to attend an upcoming, open meeting for local GPs about the commissioning project. This would be my first observation. He also directed me to the Health Authority manager (The TCG Co-ordinator) who oversaw the commissioning³⁴ process, and told me that he would be able to provide me with information about future meetings, as well as further details around the establishment of the commissioning project. I felt that the meeting with the TCG Chair had been very positive, and that he had both understood and supported my research.

I subsequently arranged a meeting with the TCG Co-ordinator who did indeed provide with further information about commissioning, and agreed to help to gain access to relevant meetings. I assumed from this meeting (wrongly, it turned out), that the TCG co-ordinator had the authority to grant me permission to observe at the commissioning

³⁴ This individual was a middle level manager, rather than the member of the Executive Board responsible for commissioning.

meetings that we had discussed³⁵. In hindsight, at this juncture, I should also have sought official permission from the Health Authority Chief Executive, or at least another member of the Health Authority Executive Committee.

I also felt that it was important to gain the informed consent of the general membership of the meetings that I sought to observe, as well as that of the Chair. I therefore wrote individually to each of the members of the Commissioning Forum (one of my principal settings). I outlined the objectives of my research and asked for permission to observe meetings, and to conduct separate interviews with participants. Upon receipt of the letters, my research was tabled as an item on an upcoming 'Forum' agenda. At this meeting, the GPs collectively agreed that they would permit me to observe Forum meetings, but also that they were too busy to be interviewed. Unfortunately, this message was never relayed to me by either the Chair or the Commissioning Co-ordinator. I was informed that the GPs did not want to take part in interviews by one of the GPs upon telephoning to arrange an interview appointment. The GPs' decision was a considerable set back, and caused me concern about continued access and the progress of the research. Over the next year, however, I was able to arrange interviews with many of these GPs by providing careful explanations about why their particular perspective was valuable to my research (Appendix 3ii).

I sought access to the Commissioning Project Board in a similar manner, and the board members agreed that I might observe their meetings. The Health Authority

³⁵ Hornsby-Smith (1993) notes the usefulness of having a 'guide' to steer the researcher through the research setting. Upon reflection, I think that I placed the TCG co-ordinator in this role inappropriately.

Chief Executive was unfortunately absent from the meeting at which this was discussed and was therefore not party to this decision. After observing one meeting, I rang the TCG Co-ordinator to confirm that I planned to attend the next project board. I was informed not only that the TCG Chair was unsure as to why I needed to continue to attend, but that the Chief Executive was reluctant for me to do so.

I then wrote to the TCG Chair explaining why I sought continued access, as well as writing to the Health Authority Chief Executive requesting a meeting in which I might outline my research, and explain why continued access was so important. I included a detailed research proposal with these letters. The Chair of the TCG agreed to allow me to continue to observe TCG Forum meetings upon receipt of the letter, but it took me several months to arrange a meeting with the Chief Executive of the Health Authority. When this meeting finally took place, I was given permission to observe at meetings throughout the Health Authority. The Chief Executive did request, however, that when I observed meetings I took a seat at the side/back of the room, rather than at the meeting table³⁶.

As well as having 'top down' access to observe the Health Authority meetings from the Chief Executive, I also wanted to have the agreement of the individual Committee Chairs. I therefore wrote to the Chairs of all of the committees that I planned to observe, to tell them that the Chief Executive had given me permission to observe, and to ask whether they had any questions or objections about this (See Appendix 3i for an example of such a letter). I succeeded in gaining access in several

³⁶ See discussion in the 'Observation' section as to my difficulty in placing myself appropriately at such meetings

cases, but each successful application took a great deal of time, thus restricting the number of meetings of which I was able to observe³⁷.

In several cases, with the changing structure of the organisation, the Chairs of relevant committees (as well as members) changed during the research period. Where this occurred, I often had to re-negotiate access. Such a change occurred in my main setting, the TCG Forum, when it became the Collaborative Commissioning Forum. The access re-negotiation required that I miss one meeting where my presence was being discussed, but continued access to this setting did not prove to be problematic.

My observations all occurred within formal settings, although I became aware that much of the decision-making and preparatory work for PCGs seemed to be occurring outside of this context. I observed work being done in brief discussions when people 'ran into' one another before and after meetings. I also heard people arranging phone calls to discuss certain issues further. I was not, however, ever able to gain access to such informal interactions. My difficulty in accessing informal or impromptu interaction was not unique to this study, although I perhaps had more difficulties because of the lack of any stable, physical location for the structures in which I was interested.

I gained access to most of my interview participants by writing to each of them individually explaining the particular perspective or opinion that they might add to my research (See Appendix 3ii). In most cases, I followed these letters by telephoning

³⁷ The chairs of three out of four of the 'Programmes of Care' committees did not respond to my request to observe. Due to other pressures, I did not follow up these requests, and limited my observations to 1 of the committees.

their place of work; several of the participants, however, contacted me upon receiving their letter. Generally, when contacted individually, GPs and managers were willing to be interviewed. I feel by outlining exactly why each individual was being included in the sample, I provided an assurance that participants' contribution would be valuable to the research.

Bell (1977) suggests that powerful people and institutions tend to deny researchers access because they do not want to expose either themselves or their decision-making procedures to scrutiny. While this may be true in other settings, I did not feel that this was the case in Casterdale. People seemed reluctant to take initial responsibility for aligning the institution to my research. However, once I attained an agreement to participate, there was a general expression of appreciation that someone was interested in what most participants seemed to feel was both a significant process, and a neglected research area.

3.4.5 Ethics

Anonymising the research setting and individual participants has been one of the greatest challenges posed by this research. The presentation of the data within this thesis and any subsequent papers is intended to minimise the possibility that either particular individuals or the geographical setting will be recognisable. Anonymity is, however, particularly difficult in relation to this research because there are a limited number of Health Authorities. In addition, as I discussed previously, Health Authorities tend to have fairly distinctive characteristics and some of the distinctive characteristics of the chosen Health Authority district are pertinent to the present research, and therefore need to be reported.

With regards to individual anonymity, participants often held unique positions within the setting. I have therefore found it particularly difficult to conceal individuals' identity without losing important contextual information. I chose to adopt the masculine pronoun for all participants (both in meetings and from interviews) as one means of protecting the anonymity of individuals within my descriptions.

While conducting my research, I was careful to point out to participants that while I could promise to conceal their individual identity, and that of the Health Authority as much as possible, I could not guarantee the absolute anonymity of either. During interviews, several people asked, 'How confidential is this?'. I responded that I would turn off the tape recorder if they would like me to, and promised that I would not repeat their comments to other participants. I also assured participants that I did not intend to name them in subsequent reports. This seemed to allay concerns in relation to other people within the organisation being able to identify their comments. Very few pertinent comments were actually made 'off the record'. In such cases, the comments have not been reported.

I was never personally requested to refrain from making notes during the meetings that I observed. I did, however, stop recording at certain points, particularly when the Chair (or other members) remarked to one another that their comments were 'not for minuting'. In so doing, I hoped to demonstrate my awareness of potential sensitivities. I felt that this was an important way for me to attain and maintain participants' trust. When I felt that the comments were absolutely crucial, I simply recorded that a discussion ensued on a particular topic.

Several people being interviewed asked me to whom else I had spoken. I sought to provide reassurance that participants were not being solely targeted within my research, without breaching the confidentiality that I had promised to others. I provided only the names of people who told me that I could refer to them personally (such as the Health Authority Chief Executive and the TCG Chair), and in other instances referred to departments in which I had conducted interviews (such as, “I have spoken to people in Public Health”).

Roth (1962) claimed that researchers never tell the subjects ‘everything’ about the objectives of their research. I maintain that I was as open as possible with participants. I spent a few minutes at the start of each interview explaining why I was conducting the research, and answering people’s questions. I also usually spent time ‘chatting’ about the purpose and application of the research once the tape was turned off³⁸. I found that by describing my research, people became more engaged, and quite quickly appreciated what information might be of interest. The focus of the research did, however, shift quite considerably during my fieldwork. Although I provided participants with a detailed account of the objectives of the study, this may sometimes have borne little resemblance to the final analysis reported in this thesis.

3.5 Observations

(See Appendices 3ii and, 3iv) for outlines relating to the organisational structures in Casterdale, and how these changed during the fieldwork period)

3.5.1 What did I observe?

My observational research was shaped by the availability and accessibility of settings in which GPs and Health Authority managers met to make commissioning decisions and to prepare for the advent of PCGs. Some of the committees that I attended predated the announcement of PCGs (such as the TCG forum, and the Programmes of Care), some were 'one-off' transition meetings, and some were either newly created, or developing structures.

My observational fieldwork consisted of twenty-five observations at formal meetings within the Casterdale Health Authority district from January 1998 to June 1999. I attended the initial open meeting of the Total Commissioning Group (TCG), in which the GP Forum members presented the prescribing initiative to colleagues (GPs who were potential TCG members), and asked them to join the TCG. I also observed five TCG Forum meetings³⁹, four TCG Project Board meetings⁴⁰ and three subsequent Collaborative Commissioning Mechanism⁴¹ meetings (essentially the form that the TCG Forum took after the formation of PCGs). I observed one Health Authority Programme of Care meeting (before these committees were disbanded in anticipation of PCGs), and I observed three Health Authority monthly board meetings⁴². I observed one PCG stakeholder meeting, and the final Primary Care Development Forum held before it was disbanded (again in anticipation of PCGs). Finally, I

³⁸ I found there were generally more questions at the end of the interview than before it began.

³⁹ The TCG Forum was the setting for GP discussion around commissioning issues and the mechanism by which representatives from the Programmes of Care (where most commissioning work was done) could report back to the Project. The Forum was advisory to the Project Board.

⁴⁰ The Project Board was the official decision making body of the TCG made up of TCG GPs and health authority management.

⁴¹ The Collaborative Commissioning Mechanism was the structure that replaced the TCG forum

⁴² Though much of the work at these meetings was conducted in 'closed' sections of the meeting before and after the public section. I was excluded from such sessions.

attended at least one open meeting of each of the PCGs soon after their transition from 'shadow' to 'real' organisations on April 1st, 1999⁴³.

Burgess (1984) emphasised that when researchers choose a single location (or conduct a case study), they should consider which social networks and clusters are relevant to understanding the interaction therein. I am aware that my observations of formal meetings only provided access to one 'layer' of decision making, and that the data that I gathered in the meetings were partially determined by the particular type of interaction that occurs within such settings. The meetings had carefully constructed agendas that determined their subject matter; they were formally minuted and managed by a Chair. I sometimes felt that these meetings were merely settings for 'reporting back' work done elsewhere, rather than being bodies where 'real' decisions were taken.

It was, however, difficult to determine when and where more informally organised work might be taking place. I asked interviewees to inform me of meetings of possible interest, but this did not yield many opportunities. The formality of the meetings that I did observe, and their infrequency, also limited my interaction with the participants, and made establishing additional 'gatekeeper' relationships difficult.

The importance of timing is often emphasised in discussions of participant observation (Burgess, 1984). I was largely excused the chore of deciding when to observe because the meetings occurred fairly infrequently and at set times. I attended

⁴³ I was away for the date of one of the PCG's first meetings, and in another instance the timing of two of the PCG board meetings coincided. For two of the PCGs, I therefore attended the second, rather than the initial meeting .

all of the meetings about commissioning or PCGs during the fieldwork period of which I was aware, and to which I was given access. I sought to conduct observations in settings that I identified either through reading Health Authority publications and policy documents, or which became apparent through the course of the fieldwork. My observational fieldwork was conducted in settings that were both as varied and as relevant as practical constraints allowed, and was driven by my intention to access data that would be relevant to my intended analysis (Miles and Huberman, 1984).

3.5.2 The Experience of Being an 'Observer'

Gans (1967) outlines three possible roles for the participant observer: the total researcher, the researcher participant and the total participant. Such different research positions are often presented as 'alternatives' that the researcher might adopt, dependant on the particular setting. I therefore (perhaps somewhat naively) entered the field thinking that I would simply choose my role in the setting. In my experience, this was actually not my choice to make. Rather, my role was largely determined by the participants, or the setting itself.

I would essentially describe my research position as that of a total researcher. I had no speaking rights in the settings that I observed⁴⁴, and was sometimes actually physically excluded from the setting⁴⁵. I certainly perceived myself to be a 'complete observer' at the start of the research process. As time went on, and I gained increasing familiarity with the jargon being used, the subject matter and the

⁴⁴ This is not to say that I would have wanted to contribute. Many researchers conducting observational work would seek to minimise their influence on the social interaction being studied. Had I wanted to contribute, however, there was no legitimate form within the formal meetings in which I could do so.

participants, I felt that I made some small contribution to the interaction that I was both observing and of which I was (supposedly) a part. As I began to understand the jokes and humorous anecdotes that were told, I began to laugh with the participants. I also found myself nodding along with discussion about topics that had been previously raised, thus displaying some understanding⁴⁵. At times, I may have come close to Gans' description of a researcher participant, but I would generally classify my position as a 'complete observer' throughout the fieldwork process.

One of the most difficult practical decisions that I faced was the issue of where I should sit during meetings. At my initial observation (the open TCG meeting), this decision was simple; the meeting took place in a lecture theatre and everyone except the Forum members sat in the theatre seats. I took a seat in the audience with the GPs. Almost all of the subsequent meetings were, however, conducted around a large boardroom table. I was unsure whether it was more appropriate for me to sit at the table or to slightly remove myself from the action by taking a seat off to one side.

At my first TCG Forum meeting, I decided to sit to the side of the room, away from the table around which the meeting would focus. Upon taking such a seat, however, one of the participants urged me to join him at the table. As I did not want to offend the GP, and I felt that as he knew the culture better than I did, I took a seat at the table. My presence at the table did not seem to be disruptive, and it allowed me to demonstrate that I was not scribbling secret, judgmental comments. I therefore chose

⁴⁵ Both being asked to sit away from the meeting table and being required to leave when public meetings entered the confidential part of the meeting.

⁴⁶ In describing both these examples, I have used the expression, "I found myself...". That is to say that neither of these small contributions were intentional, nor tactical demonstrations of understanding. I do however, also feel that these may have served to demonstrate a level of understanding to other participants.

to sit at the table in future meetings. I intended my presence at the table to indicate that I wanted to be involved in the work going on and to understand it, rather than being someone who remained an outsider, intending to sit in judgement.

As I mentioned earlier, the Chief Executive of the Health Authority later expressed that he was not comfortable that I sit at the table at such meetings; he specifically requested that I refrain from doing so. I therefore returned to my seat at the side of the room, and told those who asked me to join them at the table that I had been requested not to do so. I continued to take notes openly, and to freely let people see what I was writing.

3.5.3 Recording - To tape or not to tape?

After some of the comments that were made during my initial interviews with the TCG Chair and the TCG Co-ordinator, I had the impression that audio taping meetings would be seen as overly intrusive. Through these interviews, I became aware that some of the resource allocation decisions taken at the meetings were particularly likely to be sensitive topics. I judged that even requesting to tape record such interactions might earn the mistrust of participants, thus hindering the progress of my research.

From speaking to colleagues, I also learned that recordings of meetings with up to twenty participants would be extraordinarily difficult to transcribe, and the resulting data might be very muddled. I therefore opted to take hand-written field notes during the meetings, and I feel comfortable with this decision. My furious note taking was done openly, and did not seem to cause any significant disruption. I developed a

personalised shorthand by which I could identify the speakers in my notes. I put descriptive notes in brackets, and thus these were easily distinguishable from my notes of members' comments or actions. Wherever possible, I recorded participants' contributions verbatim.

I transcribed my field notes as soon as possible after the data collection. I gave this task priority over other fieldwork chores, and it was usually completed within twenty-four hours. It was quite common for me to add several points that I remembered while 'writing up' my notes that I had not written down at the time, and to add more detailed personal reactions. I was careful, however, to distinguish these from the original notes.

3.6 Interviews

3.6.1 Interview data

Besides my observations, interviews were the other most significant part of my data collection. I sought to interview actors involved in implementing the changes at the local level – mainly local GPs and Health Authority managers. In addition, I wished to talk to key informants who contributed to shaping policy at the national level. These interviews were conducted both before, and alongside, my observational research.

The interviews and observations were used to both support and build on one another – during both the fieldwork and the analytic processes. I did not approach the interviews as a means of 'testing out' what I observed, but rather intended them to provide a different perspective to the observational research, and to add depth to my

overall understanding. Heritage (1984a) stated that treating interview data as an appropriate substitute for observing actual behaviour is a mistake; the data that one attains through interviews are fundamentally different to those attained through observations.

In conducting interviews, I aimed to gather accounts of the change process and people's role in it. I wanted to gain the perspectives of individuals from the different 'interest groups', from people who were working both in the management of GP commissioning, and later in the establishment of PCGs. I expected actors' accounts to enable me to further explore the issues that people identified as being relevant and important, and to help me better understand the rules and conventions of the social world from the participants' perspective. Accounts provide the researcher with access to the means by which people fit actions into meaningful frameworks, and as such they may reveal underlying structures or order (Bryman, 1988)⁴⁷.

3.6.2 Who was interviewed?

I conducted thirty-four interviews over the eighteen months of fieldwork.

I interviewed fifteen local GPs involved in the commissioning and/or PCG implementation process. All of these GPs would eventually hold positions on PCG boards. Several GP's either became PCG Chairs, or already held this position at the time of interview. Eight of the GPs who were interviewed had been members of the TCG Forum, and two were former fundholders. I interviewed both the present and the recently 'retired' Chairs of the LMC.

I interviewed employees of the Health Authority at various levels of seniority. At the Board level, I interviewed the Chief Executive, the Chair, and the Acting Director of Commissioning (who oversaw the implementation of PCGs). I also interviewed the TCG Co-ordinator (twice), two PCG Project Managers, a GP who had become a Public Health Consultant, the Commissioning Co-ordinator, all of the PCG Implementation Officers, and the Health Action Zone (HAZ) Co-ordinator⁴⁸.

In addition, I interviewed one local GP (not on any PCG board) who held an office with the Royal College of General Practitioners, the Chief Executive of the LMC (a manager rather than a GP), and a GP (not from Casterdale) who was an MP holding a position on the House of Commons Select Committee for Health⁴⁹.

Burgess' (1984) description of 'key informants' is probably the closest approximation to how I selected the individuals for interview. I did not intend my sample to be statistically representative or empirically generalisable. Rather, I sought to access a sample of informants who were likely to hold different perspectives of the change process. I identified representatives of pertinent categories before fieldwork began (such as fundholding GPs, health authority managers, TCG GPs), and identified several new categories during the fieldwork itself (PCG chairs, PCG implementation managers). The accounts given in the interviews reflected not only such different 'types' of people, but also the different stages in the transition to PCGs.

⁴⁷ See section 3.3.1.

⁴⁸ See Appendix 3vii for a brief description of each of these roles.

⁴⁹ This committee had recently compiled a report on PCGs.

I also identified a pool of potential interview participants from the Health Authority managerial staff whose work primarily consisted of working with GPs, and local GPs who were involved with managerial work either through commissioning or through holding elected positions the new PCG boards. My knowledge about the potential sample developed over time, and rested largely on information gained from observations and previous interviews. I asked people who I interviewed to suggest others who I might approach, and I slowly built a 'network map' of potential informants within Casterdale.

The development of new PCG related positions was another source of potential participants (PCG Chairs and implementation managers being two such examples). In these cases, I sent letters to each of the newly appointed (implementation managers), or elected (PCG Chairs) individuals, asking if they were willing to be interviewed. I met each of the PCG Chairs and Implementation managers at some point during my fieldwork (some of them were interviewed before they took up their new posts). I would have liked to interview the PCG Chief Executives (who would take over PCG managerial/administrative tasks in relation to PCGs from the implementation managers once the 'shadow period' was over), but these individuals were put into post too late to be included in my fieldwork.

I am (and was) aware that my sample of GPs consists mainly of 'enthusiasts'; all of my participants were somehow actively involved with the change process. I therefore also sought to identify and interview local GPs who were disaffected with the change process, and who had not been interested in commissioning. Interviewing 'non-

enthusiastic' GPs might have provided insight into a more critical rhetoric regarding the reform measures. I found it very difficult, however, to make contact with such GPs, and to make my research salient to them. I used one of the stakeholder meetings as an opportunity to talk to 'regular' (non-enthusiast) GPs, and found that they generally were unenthusiastic about engaging in discussion about the proposed PCGs. Additionally, they expressed discomfort over speaking about the changes with which they had little active involvement. Attempts to arrange further interviews were unsuccessful.

I also intended to include GPs who were actively resistant to the proposed reforms in my sample. One of the GPs who I interviewed in the early part of my fieldwork provided the contact details of three fundholding GPs who he identified as being unhappy with the proposals, and who were not intending to co-operate with the formation of PCGs. I wrote to these three GPs explaining my research, and asking if they would agree to be interviewed. I subsequently telephoned their practices in an attempt to set up an appointment. I was disappointed that none of these GPs expressed a willingness to be interviewed.

The data that I collected (both the interviews and the observations) therefore relate not to GPs in general, but rather to GPs who chose to become actively involved in commissioning and/or were taking leadership roles within the newly forming PCGs. It is important for me to recognise the specificity of my sample in relation to the way that the data can be analysed – particularly in relation to any contribution I might be able to make to the professions literature. Many of these GPs had been 'politically

active' for some time through the Local Medical Committee (LMC⁵⁰), or other professional structures. They also tended to have a certain amount of local influence beyond their own practice. Such individuals can either be seen either as the 'forward thinking' or the 'compliant' members of the general practitioner profession, depending on one's perspective.

3.6.3 Of what did the interviews consist?

My first interview (with the chair of the TCG) served three purposes: to negotiate possible access, to learn more about the setting, and to gain the Chair's perspective on the reform initiatives. Before this interview, I constructed a list of questions that I intended to cover. The interview, however, ran much more like a conversation than I had imagined it would, with the respondent almost always leading the discussion; I did not rely on my planned questions to the extent that I had thought I might. When the interview was finished and I listened to the audio recording⁵¹ alongside my intended questions, I was able to confirm that we had covered almost everything that I had wanted to discuss.

My next interview, with the TCG Co-ordinator, similarly had multiple purposes. The perspective or 'expertise' of this interviewee was quite different to that of the TCG Chair, and so I prepared a different set of questions for this interview – although many of the topics overlapped with those from the previous interview.

⁵⁰ The Local Medical Committee is an organisation that works to represent and protect the interests of general practitioners and general practice.

⁵¹ I asked each person interviewed if they would mind if I taped the interview. I explained that this would allow me to listen without having to scribble down notes. All of those interviewed agreed.

Essentially, I conducted my preparation for each interview in this way. Each of the participants had somewhat different relationships with (and potentially, perspective on) the changes that were occurring; and thus the questions that I asked varied accordingly. The timing of the interviews also shaped the relevant questions and topics. Issues that were salient to managers and GPs soon after the release of the White Paper were quite different from those close to the 'going live' date (April 1st, 1999).

After the success of the early interviews, I decided that while I would plan which topics I intended to cover, I would not set out a particular path of questions. I therefore began to plan interview *guides* rather than *schedules*. I wanted to build on participants' willingness to lead the discussion, and to allow them to identify important issues, and to direct the interview. Over time I gained the confidence to take a more relaxed approach to the interviews. My decision not to use a single interview schedule, however, meant that I was not always able to use the interview data to directly compare different participants' responses to the same/similar questions. I did not find this to be *particularly* problematic, but it did sometimes limit my ability to establish whether a particular view expressed was generally held, or reflected a more unique personal opinion.

I began each interview by briefly explaining the purpose of my research to the interviewee. Subsequently, I tried to minimise the number of questions that I asked. I sometimes asked people to expand on certain responses, and to 'follow on' questions to topics that had been raised. I also worked to guide the conversation into new areas when we seemed to have exhausted discussion on a particular topic. This conversational approach seemed to work well. There were few instances where the

conversation wandered far from my area of interest, and there were numerous instances where interviewees led the discussion in relevant directions of which I had previously not been aware.

I transcribed each interview in full for the purposes of consistency, and because I could not fully predict what might be of interest or relevance later in the analysis. There were, however, a few points in the tapes where I could not make out what was said, and I had to omit these passages. There was also one interview (with one of the Implementation Managers) that was completely inaudible⁵².

I feel that the interviews were often shaped by the amount of time that the different individuals felt able, or willing, to spend with me. The letter that I sent out requesting an interview specified that I intended that this process should take less than an hour. Most of the interviews took place in the respondent's place of work (though one GP came to my office). For many of the GPs, the interview was inserted in between morning and afternoon surgery. The average interview lasted about an hour, although the length did vary considerably.

The process of conducting interviews with GPs often reflected hectic working lives (an issue that was also brought up by the GPs in the interviews themselves). One GP ate lunch during the interview, (and gave me some very nice kiwi and grapes), one was over an hour late due to extended home visits, and one interview took place in

⁵² Because I was carrying out interviews and observations side by side, 'transcribing' my field notes and taped interviews was sometimes an enormous burden. I prioritised transcribing observational notes, as these relied more heavily on my memory of events than interviews. Consequently, some taped interviews waited several weeks before being transcribed. This was the case with the inaudible tape of the interview with the implementation manager. I had not taken field notes, and no detailed record could be reconstructed without the tape.

such a crowded surgery that I had to (literally) step over an ante-natal class to reach the GP's office.

One of the GPs telephoned through to their receptionist as soon as I sat down, asking them to hold all of their calls for thirty minutes. I therefore concluded that I had less time for this interview than for others. On the other hand, two of the GP interviews ran for nearly two hours. Both of these interviews included unprompted and fairly lengthy life histories⁵³.

The interviews held in the Health Authority posed different challenges. They were frequently interrupted, and the 'open plan' workspace for all but senior managerial staff meant that interviews often had to be conducted in borrowed offices or 'bookable' rooms. The lack of available private space seemed to limit the time available for each interview. I also judged that the Health Authority staff were only able to legitimise (to themselves or others) spending a certain amount of time with me (seemingly up to about an hour). In contrast, the length of time that I spent with the GPs seemed to be less constrained by a sense of being subject to moderation, but rather, more determined by GPs' level of interest, or the timing of the next surgery⁵⁴.

After about nine months of fieldwork, I felt that I had a relatively good understanding of the changing structure of work related to commissioning and the formation of PCGs. I was therefore able to place the people that I had interviewed within some kind of organisational map in relation to my research. I then began to identify people to whom I had not yet spoken, who might have a different perspective on the change

⁵³ One of them also included several cups of coffee.

process, and I set out to arrange interviews with these people. In hindsight, I have come to see this mapping of interviewees, and identification of ‘gaps’ in my data map as an early part of my analytic work. My expanded model of relevant categories within the research setting, and gaps in my data, was analytically driven.

In drawing up this conceptual map, I began also to consider when I should bring the field work to an end. I concluded that since I began my fieldwork around the time that the preparation for PCGs began, it would make sense to finish my fieldwork at the point in which (or soon after) the PCGs were officially in place. Thus, my fieldwork would end with observations at the first or second (due to practical limitations) open meeting of each of the PCGs. I did not interview anyone after my last observation.

3.7 Documents

The third aspect of my ‘fieldwork’ was a limited documentary analysis of the White Paper, *The New NHS*, and a compilation of other publications relating to GP commissioning and the reform implementation (such as TCG Newsletters, Meeting Minutes, NHS Executive Circulars and PCG guidelines).

I used the White Paper and the other documents to provide context for the action that I was observing, and the accounts with which I was being presented in Casterdale.

Miller (1997) describes texts as being central to how people make sense of social reality - how such reality is constructed, sustained, contested and changed.

Institutional texts can provide access to the social contexts in which they are produced

⁵⁴ Though this is just supposition.

and sit. As such, documents warrant consideration in their own right. For my purposes, however, I only engaged with the official documentation as ‘anchors’ for the action and accounts that are central to my analysis. Miller (1997) maintains that although institutional texts do not determine the meanings that actors assign to the everyday world, they do facilitate some interpretations over others. Through official documents, members are provided with procedures and categories with which to classify events, people and issues. The extent to which official documents shape the way that people think about or present their acts, without necessarily determining the acts themselves is therefore important.

My documentary analysis focused on *The New NHS*. I read the White Paper soon after it was released, before I began my observations or interviews. I reread it several times early on during my fieldwork, intending to identify the Government’s stated objectives for the reform initiatives, and the way that these were justified both to health care workers and to the public. The stated aims and objectives of the reforms were important to my analysis. I returned to the document several times during the different stages of my analysis, and these re-readings shaped the construction of the coding framework. How did the local actors demonstrate adherence to the policy rhetoric? How was this official adherence moulded into workable local structures? Miller asserts that one is able to demystify institutional authority by demystifying institutional texts. Through this research, I aim to explore how the White Paper (as an example of a reform initiative) was acknowledged, incorporated and applied at the local level.

3.8 Analysing the data

The process of qualitative analysis is another aspect of the research process (like gaining access) that is often only given scant attention when results are reported. Frequently, little detail is provided in relation with regards to how (or on what basis) analysis was conducted, and accounts are often limited to, “.....then the data were analysed.” The lack of attention to such matters is problematic. For one thing, the ‘fog’ surrounding qualitative analysis makes it quite difficult for a new researcher to learn by following the process of her predecessors.

I therefore include the following account of my analysis not as any sort of methodological ‘showcase’, but rather in recognition that the reader should be given some means by which to follow the links that I make between the data that I collected, and the analysis that I constructed. I also feel even if my methods were somehow flawed, this is an important part of the record of my research. Furthermore, the shortcomings that are displayed are due, at least in part, from a lack of existing models on which to build – a situation that I would like to begin to address.

3.8.1 Constructing a Coding Framework

Creswell (1994) describes qualitative data analysis as being essentially a process of data reduction and interpretation. Qualitative analysis involves reducing huge amounts of data into categories, to which theoretical schemas can be applied for the purposes of interpretation.

My analysis began (in a very informal sense) in the earliest stages of the fieldwork process. Unless one’s research is totally inductive, a certain amount of analytic work will accompany the planning and implementing of data collection. The questions and

issues that inform the research process should be analytically informed, if not driven. Once the fieldwork began, I started to identify further questions. I also began to note interesting aspects of the interaction that I was observing, and the accounts with which I was being presented through interviews.

I continued to build my literature review while conducting fieldwork, and I kept a file of questions that emerged from what my reading seemed to tie in with what I was finding 'in the field'. My on-going reading of the literature provided structure and insight into the picture that I was attempting to build with the data. I kept a set of scribbled notes and jottings of things that struck me in relation to my research, and this served to inform my construction of an initial 'coding framework'.

The majority of the 'serious' analytic work, however, was conducted towards the end of the data collection process, and over the next several months. This consisted firstly of building a framework of ideas in which to set my raw data, and then utilising the newly 'organised' data to address questions raised from reading the sociological literature, as well as from the data themselves. In order to construct this framework, and to usefully organise the data, I found that I needed to be very familiar with both the content of the data and the relevant literature. I had to decide:

1. What questions might the data insightfully address?
2. How might I best 'label' and organise the data in order to address such questions?

When I thought about 'analysing my data' before I began doing research, I had simply imagined applying some sort of categorisation process to my transcripts. I had thought that somehow, through this process (that I termed 'coding'), the meaning of the data, and the relation to my questions would somehow become clear. I had

conceived of the coding framework as a tool that would somehow ‘magically’ appear from the data, and which I could then use to make my data ‘useful’. I struggled for some time trying to identify from where such codes (that would make up the coding framework) would come. I feel that one of the most important things that I learned from this research is that constructing a relevant coding framework is actually a major part of the analytic process, and depends both on the researcher drawing together significant ideas and questions from the existing literature, as well those emerging from the data.

In my first attempt to construct a coding framework, I read the transcripts from the interviews and observations that I had conducted, as well as occasionally referring to relevant documents. I made a note of all of the topics that I could identify within the data. Some substantive topics emerged directly from the transcripts (such as ‘physiotherapy’, ‘clinical governance’ or ‘remuneration’), while others more theoretical areas drew more heavily on existing theory within the literature (such as ‘GP involvement’, ‘control’ and ‘autonomy’). My intention was to compile an inclusive index of the issues raised in the fieldwork, and to relate these to the areas of interest in the literature; I read each of the transcripts twice for this purpose. These initial readings resulted in the identification of over one hundred different topics, and is included as Appendix 3vi. I began to identify considerable overlaps between the topics, and realised that this particular ‘organisation’ of the data would be of limited use in defining the pertinent questions from my data. I therefore decided to aggregate the topics, and developed six larger themes from within the data that I felt related to the existing literature.

Next, I began to consider what questions my data might fruitfully address, and attempted to organise the data appropriately to facilitate such a process. The ways in which the ideas and structures surrounding the health care reform (as illustrated through *The New NHS*) were operationalised by those working within each Health Authority district emerged as a particular interest. I focused on three ‘themes’: ‘Negotiation’, ‘Control’ (which was eventually further subdivided into ‘Decentralisation’ and ‘Control over Practice’) and ‘The Professional Agenda’⁵⁵. At this stage, these themes were still ‘working tools’ rather than firm constructs upon which I would build my analysis.

I then re-read the transcripts yet again in groups that related to the ‘type’ of data that they provided, with a clearer idea of the questions to which I sought answers. I read all of the transcripts from The Commissioning Group (TCG) Forum meetings first, followed by the TCG Project Board meetings, Health Authority board meetings, Implementation manager interviews and so on. I constructed a summary of the central issues dealt with in each transcript. I also noted the twenty-five or so concepts that seemed to be both recurrent and relevant across the transcripts. I then attempted to elucidate what was meant by each such concept, how it might be important to my identified questions, and how it related (and often overlapped) to the others. I made cursory ‘coding notes’ on the transcripts themselves during this process.

⁵⁵ Each of these will be discussed more fully in the data chapters that follow. Negotiation, Decentralisation and Control over Practice become the foci of individual chapters, and a discussion of a Professional Agenda is a theme that runs through all of the chapters.

I then revisited my original 'topic index' coding framework and merged it with the three themes (that had been refined through the subsequent rereading of the data).

This formed a second coding framework (See Appendix 3ix) that was more hierarchical than the first, and that went beyond simply attempting to index the different topics.

Up until this point, my analysis involved simply extracting topics and themes from the data (drawing upon existing literature). The next stage, however, involved applying my coding framework to the data, such that the transcripts could be dissected in numerous different ways, depending on the aspect of the data in which I was interested (or what question I wanted to consider). I therefore re-read all of the 'hard copies' (printed versions) of my transcripts, and isolated extracts from observations and interviews that related to the themes and topics. Some parts of the transcripts related to several different topics (and even more than one theme); I coded these parts several times. At this time, I also re-read *The New NHS*, and extracted text that seemed to relate to my identified themes.

Finally, I entered my transcripts into a qualitative data software package (NUDIST), and transferred the coding work that I had done with the hard copies into electronic data files using this computer programme. In the next short section, I wish to briefly discuss my use of NUDIST, and to raise some issues relating to my decision to use a computer package to facilitate qualitative analysis.

3.8.2 Using Computer-Assisted Qualitative Data Analysis Software: *NUDIST*

I decided to use a software package to help with data analysis because I thought that it would help me to organise my data. I expected a qualitative data analysis package to facilitate drawing different aspects of the data in relation to particular questions or issues. I chose NUDIST primarily on pragmatic grounds; I was already familiar with the software and I already had it loaded onto my computer. This choice saved me the expense and time of choosing, buying and learning a new package.

I entered my coding framework onto the NUDIST package, and transferred my interview and observational transcripts into the ASCII files that the programme required. Using NUDIST, I electronically re-coded the data from interview transcripts and observational field notes. The computer package allowed me to store the coded 'chunks' in such a way that they could be retrieved in many different forms. This process took about two months.

By the time that I came to enter the coding into the NUDIST software, I was confident that the codes that I had developed were fairly stable entities. By reading the transcripts several times, and subsequently revising the coding framework, the codes had become well-defined. I therefore decided to re-organise the transcripts for the re-reading that I would do in relation to the 'electronic coding'. I chose to 'cluster' interviews and observations according to their connections with one another. I read the interviews of the implementation manager and the chair of each PCG alongside my field notes from my observation of the PCG board meeting. I then read the commissioning interviews and TCG field notes together. This process helped me to elucidate different perspectives and understandings. In particular, this enabled me to build new 'bridges' between interview accounts and observational data.

Upon reflection, I am not sure that using NUDIST was terribly 'efficient'. I applied an enormous number of codes to the transcripts, but I have only been able to incorporate a tiny portion of these into my analysis. Additionally, the transfer of 'hard copy' coding to the 'electronic' coding was very time consuming, and may not have greatly extended the analytic process (although with greater confidence one might 'skip' the hard copy coding stage). The data sets that were produced by NUDIST were also of limited use; I found it very difficult to get the right balance of including enough contextual identification, without being burdened with enormously long data extracts.

I may not have taken full advantage of 'theory building' capabilities of the software, and although it served useful as a means by which to organise my data, it was perhaps an overly expensive investment of time. I do wish, however, to acknowledge the extent to which using a computer package seemed to provide my research with a certain level of legitimacy with participants and others with whom I discussed my analysis. Using computer software seemed somehow to legitimise my qualitative analysis (essentially making it more like quantitative analysis) to both participants and others, even though the computer package is simply a tool being used by the researcher.

3.9 The Next Stage of Analysis – applying the data to the important questions

What I failed to appreciate before I began my research, and in fact, before I began to write my data chapters, is the extent to which analysis is actually accomplished through the process of writing. Although I recognised that one's fieldwork plans,

data collection and analysis are entwined, I had envisioned writing as a separate stage that would follow.

Perhaps this goes some way to explain my disappointment with the utility of NUDIST software. I had expected that once I had studied the printouts that this software would allow me to produce, my analytic work would (for all intents and purposes) be complete. I could then sit down to record what I had found (or NUDIST had displayed), and how this related and indeed how it expanded, existing research. I was therefore somewhat perplexed when such clarity did not emerge, nor did the enormous printouts provide clear indications of how my data might be applied. The writing process was not one of simple recording, but rather one of formulating, applying, revising and rebuilding my ideas. Indeed, the need of precision in written work often demonstrated weaknesses and contradictions in my analysis. The difficult process of constructing the chapters and presenting the data contained therein was a complex, but fundamental part of the analytic process.

In conclusion, the body of this thesis simply builds upon the discussion of what I did, how I did it, and why I chose to do it that way. I maintain, however, that one of the most important lessons from this research was the extent to which the analytic and writing processes are necessarily and unavoidably enmeshed.

My next task is therefore to present what I found – the issues on which I chose to focus in the data. The three data chapters that follow are closely related to the ‘themes’ that I have already identified. These themes relate to aspects of the data that address important issues in the literature. The first two chapters focus on topics identified within the White Paper (‘decentralisation of authority’ and ‘control over

clinical practice') as they were implemented in Casterdale; they relate closely to the ongoing debate over professional power and autonomy. The final data chapter is somewhat different; it focuses on the way that the reform implementation was managed at the local level, rather than any substantive topic raised through the reform process. My hope is that this chapter will contribute to ongoing debates within several literatures; namely academic dialogue with regards to policy implementation and organisational change, as well as a better understanding of professional/managerial relationships.

4. The New NHS as a delegation of authority or an abdication of responsibility?

“Decisions about how best to use resources for patient care are best made by those who treat patients – and this principle is at the heart of the proposals in this White Paper. For the first time in the history of the NHS the Government will align clinical and financial responsibility to give all the professionals who make prescribing and referring decisions the opportunity to make financial decisions in the best interests of their patients.” The New NHS (1997: 9)

4.1 Introduction

The New NHS proposed a fairly radical organisational restructuring of the delivery of health care, including delegating decision making from both central government, and local management to local professionals. The policy document presented this delegation as presented as a way of utilising local expertise to promote greater efficiency and effectiveness within the service. The increased involvement of professionals was described as serving to ensure that care is based upon identified local needs, and that resources are channelled appropriately.

In this chapter, I will examine the rhetoric of decentralisation within *The New NHS*, and the ways in which policy makers formulated this to appeal to different influential stakeholders. I will then analyse how the official policy rhetoric was interpreted and applied at the local level. This analysis will be informed by referring to the history of similar reform measures since the inception of the NHS.

The history of the NHS reveals that decentralisation is not a new concept. Indeed, similar initiatives were already in place in Casterdale in the form of the Total Commissioning Group. This history shaped the decentralisation of resource allocation decisions in Casterdale; existing local professional and managerial co-operation and collaboration was used as a basis for the continuation and expansion of 'meso' level professional involvement alongside (or above) the more localised involvement within PCGs. The history of local collaboration was one mechanism by which the effects of the Government initiative were mediated. I will discuss possible motivating factors for the displays of support for cross-PCG collaboration by both GPs and Health Authority management, as well as why (by the end of my fieldwork) such collaboration faced heavy criticism from certain quarters.

The Casterdale data suggest that the actual delegation of decision making to local professionals was more complex than was officially indicated in the White Paper. The priorities and strategies of the central policy makers, local Health Authority managers, as well as local GPs were all incorporated within the decentralisation process. One might have expected that delegation of decision making to local professionals would lead to a major reformulation of power relationships - both between the centre and the periphery, and between local management and professionals. I propose, however, that the Casterdale data illustrate that delegation was restricted to quite specific areas of work, and that the reforms therefore posed few significant challenges.

One of the key issues to emerge in relation to the local implementation of decentralised decision making was the continued role of the Health Authority. The

local managerial structure as operationalised within the health authority was challenged through the reform rhetoric – and the continued role for the health authority was not clear. Greater professional involvement in managerial work was interpreted by some local actors as posing challenges to the power of Health Authority management. Different actors' perceptions of the role of the health authority seem to have shaped the decentralisation process. In the following chapters, I will consider the extent to which Casterdale Health Authority was able to retain (and/or develop) its influence.

The New NHS' stated objective of decentralising decision making can be seen as necessitating a concurrent reduction in centralised control. The Casterdale data, however, suggest that central control did not necessarily diminish with the move towards decentralisation, but instead was often developed through new (and potentially stronger) channels. The development of central control alongside the process of official 'decentralisation' was important to the local implementation of *The New NHS*.

This chapter will conclude by reflecting upon the extent to which the decentralisation initiative was successfully incorporated and utilised by Health Authority managers and GPs - as well as policy makers. One of the central issues will be how decentralisation has been used to serve these actors' respective, and often competing, agendas.

4.2 The official rhetoric of decentralisation within ‘The New NHS’

The actual motivation behind any reform initiative is inaccessible, even perhaps to those involved in its formulation. A more fruitful avenue for sociological research is to consider the process of reform implementation, focusing on the apparent benefits of any decentralisation initiative for influential actors. My intention is that through my analysis, I may offer insight into the impetus for the reforms, as well as their reception at the local level. This, in turn, could inform a better understanding of both how and why reform initiatives took the shape that they did within Casterdale.

The delegation of decision making to the new PCG structures was defended within the White Paper through the inclusion of numerous statements that outlined the potential benefits of allowing local professionals to control the allocation of resources for local populations.

“For the first time in the history of the NHS all the primary care professionals, who do the majority of prescribing, treating and referring, will have control over how resources are best used to benefit patients.” The New NHS (1997: 37)

“Local decision rather than national edict will determine the future Health Authority map.” The New NHS (1997: 30)

“It will provide local family doctors and community nurses with maximum freedom to use the resources available to the benefit of patients, with efficiency incentives at both Group and practice level.” The New NHS (1997: 19)

The policy rhetoric built upon an assumption that local professionals are in the position to *really* understand and to care about the needs of their patients. In adopting such a stance, the policy defines health care needs as objective entities that can be accurately defined and addressed. On this basis, the proximity of professionals to their patients, as well as their relevant expertise, provides them with valuable insight that can then be applied to developing more appropriate resource allocation.

Attempts to incorporate GPs into decision making could also be interpreted as attempts by policy makers to draw upon cultural images of altruistic and ‘patient-focused’ professions in order to legitimate necessarily difficult and long-standing resource allocation decisions. Thus, it would not be the incorporation of local professionals into decision making structures that is key, but rather the delegation of responsibility for such tasks to professionally led structures.

“Clinical and financial responsibility will be aligned. Primary Care Groups will be able to take devolved responsibility for a single unified budget.” The New NHS (1997: 19)

4.2.1 Decentralisation as part of a history of reforms

The fact that *The New NHS* draws upon the idea of ‘decentralisation’ to legitimate the changes being introduced is potentially significant when considered alongside the

history of previous such reform initiatives. Hughes and Dingwall (1990) noted that each of the NHS reviews since 1974 has recommended a devolution of control from the Department of Health to local decision makers who have better knowledge of local circumstances. Flynn's (1992) analysis of the 1974 reforms drew a similar conclusion; the reform was based on the principle of maximum delegation downwards, but also coincided with moves to strengthen accountability structures upwards. Thus, the reforms supported local consensus and decision-making, while also attempting to establish a vertical hierarchy of command. More recent reforms have also officially prioritised decentralisation of control. The delegation of power and authority to local levels was presented as a key aim of the 1989 policy initiative, *Working for Patients* (Kelly and Glover, 1996). Delegation to the local level was described as being a way to make the service more responsive to patients, thereby contributing to the development of a more 'consumerist' philosophy.

The inclusion of decentralisation initiatives within previous reform measures serves as an important anchor for the present research, even though the decentralisation initiatives were presented as being quite revolutionary within *The New NHS*. Flynn's identification of entwined initiatives to delegate work and augment accountability structures has strong resonance with the 1997 reforms. The 1997 initiatives seem similarly to seek to balance decentralisation initiatives with efforts to augment control over local professional practice. As already outlined, the reform rhetoric clearly states that the introduction of new organisational structures within the NHS was intended to facilitate a decentralisation of key managerial tasks to local professionals (essentially GPs), as well as to ensure that such professionals were made accountable for their performance in such tasks.

“Health Authorities will allocate funds to Primary Care Groups and hold them to account.” The New NHS (1997: 22)

“Health Authorities will devolve responsibility for direct commissioning of services to new Primary Care Groups as soon as they are able to take on this task. Such an approach provides a ‘third way’ between stifling top-down command and control on the one hand, and a random and wasteful grass-roots free-for-all on the other.” The New NHS (1997: 25)

To this extent, the policy was presented as paving the way for a delegation of tasks to local professionals through the introduction (or augmentation) of structures intended to monitor professional practice in this regard. A careful consideration of the decentralisation elements of the reform process therefore potentially addresses pertinent questions:

To what extent should decentralisation be understood as an expansion of professional influence?

To what extent is decentralisation better understood as facilitating the extension of central control over professional practice?

My analysis abandons the notion of judging whether decentralisation efforts have ‘succeeded’ or ‘failed’, but rather seeks to understand how decentralisation is incorporated into distinct agendas, and how this shapes the organisation of professional practice at the local level.

4.3 A changing role for GPs? The actual delegation of tasks within Casterdale

In the following sections (4.3.1-4.3.4), I will outline several facets of the decentralisation initiative as revealed by the Casterdale data. These data raise questions regarding the extent to which this initiative should be considered as a delegation of authority beyond the rhetorical level, issues that will be addressed later in this chapter (Section 4.7).

4.3.1 Official delegation of decision making to local professionals

According to the White Paper's rhetoric, the introduction of PCGs would greatly increase the involvement of GPs in influential decision making and resource allocation structures. GPs would become central to the newly formed structures that were being established to ensure an efficient and effective approach to care.

"The new financial arrangements will promote access to high quality care right across the country by allowing clinicians to influence the use of resources by aligning clinical and financial responsibilities." The New NHS (1997: 69)

Unlike the previous fundholding initiative, however, *The New NHS* reform measures were compulsory; all GPs working within the NHS were obliged to join a PCG⁵⁶. Thus, the enveloping nature of *The New NHS* reforms allowed the Government to make references to 'wide scale professional involvement', even though this

⁵⁶ One way that this 'GP conscription' was justified by the Government was that it was a necessary measure to tackle the heavily criticised 'two-tiered service' that had developed under fundholding.

involvement was often not voluntarily offered. The mandatory nature of GP involvement with PCGs rendered this a relatively worthless measure of increasing professional involvement in managerial tasks or resource allocation. Initially, talk of professional resistance to the new structures was prevalent. Nevertheless, GPs generally (and universally in Casterdale, as far as I am aware) conceded to joining a PCG, thus becoming officially 'engaged' with the managerial process.

The extent to which membership of a PCG entailed increased engagement with the tasks outlined within the White Paper for the majority of GPs remains quite questionable. Data suggest that active involvement in these tasks remained limited to quite a small number of individual GPs (many of whom had previously been active in local professional politics and management). Furthermore, while the official policy documentation simply described professional involvement in 'decision making' and 'resource allocation', analysis reveals that there were particular areas where professional involvement was acute, and others where control was firmly retained (or even strengthened) by central government or by local management.

4.3.2 A continuation of existing structures: GP involvement in resource allocation and cost control before the advent of PCGs

The White Paper's rhetoric emphasised the importance of greater professional involvement in resource allocation decisions for the decentralisation initiative.

Although *The New NHS* presented professional engagement with such tasks as being relatively revolutionary, the Casterdale data revealed that GPs were already officially engaged in such work through locally formulated structures. Furthermore, it seems that it was the official engagement of professionals in essential rationing tasks that

was revolutionary, rather than the engagement itself. Klein (1995) suggests that health authorities have historically avoided having to adopt rationing policies by unofficially delegating these decisions to clinicians. In so doing, both local management (and indirectly, central government) have been able to shift 'blame' for unpopular decisions, and have been able to avoid taking responsibility for any necessary rationing.

I observed ongoing efforts between local GPs and Health Authority managers to create and refine workable structures through which resource allocation might be determined. Much of the work of the TCG and the early work of PCGs (not including the time spent on determining structural arrangements) involved prioritising local services and allocating available funds. Furthermore, this work involved establishing and monitoring the structures through which resources were allocated (such as the Programmes of Care, the cross district prescribing committee, and the clinical guidelines committee).

The emerging structures provided local professionals with limited additional powers to focus resources towards meeting particular community needs. This extended role was conditional upon GPs agreeing to define areas where spending might be reduced⁵⁷. Through active involvement in such work, the TCG and PCG GPs were inevitably being further drawn into the official work of 'rationing' resources. The ideological notion of 'rationing' was ingrained in the White Paper initiatives, but it

⁵⁷ Allen (1996: 21) reflected on the augmented role for doctors, nurses and general managers in the effective allocation of resources in the 1990 reform, and posed the question of whether this role expansion was enabling or controlling for those involved.

had also underpinned the local TCG structure that preceded them⁵⁸. The following three sections of this chapter will provide examples of some of the ways in which GPs were increasingly engaging with (and taking responsibility for) difficult decision making and cost control measures under the umbrella of ‘resource allocation’.

4.3.2.1 The Total Commissioning Group: controlling prescribing budgets

Measures to collectively control professional prescribing practices were central to the TCG initiative. With the establishment of the TCG, local GPs took on the task of actively monitoring and shaping colleagues’ prescribing behaviour, thus ensuring greater control over the district’s prescribing budget. Thus, these GPs became responsible for ensuring that the Casterdale Health Authority stayed within a defined prescribing overspend⁵⁹.

Previously, such responsibility had fallen to Health Authority managers, with the consequence that prescribing would regularly exceed the budget allocation. It was common for the district to run out of money long before the end of the financial year. In such a system, GPs had served their patients by prescribing according to the needs of individuals, regardless of the effects of such decisions on the overall resource allocation; GPs’ new role within the TCG, however, required them to balance the two (often conflicting) responsibilities.

⁵⁸ See Chapter 2 for a discussion of rationing in relation to a ‘collective’ or ‘individualistic’ notion of health care.

⁵⁹ The Health Authority accepted (on the basis of previous years’ spending) the inevitability of a certain overspend in relation to the centrally defined prescribing budget.

The TCG was supported by the vast majority of local GPs (see chapter 5 for a fuller discussion). The Health Authority appropriated GPs' involvement in monitoring prescribing spending by establishing a financial incentive scheme associated with the initiative. The incentive scheme instigated through the TCG was organised at the district (rather than the practice) level, and aimed to strengthen peer pressure and collegial control. In order for any one practice to receive the financial 'reward', the entire project had to remain within the budget. The prescribing initiative offered GPs a chance to access relatively flexible resources for additional primary care services. In addition, for a group of particularly active GPs, the scheme facilitated a considerable extension to their professional mandate.

Perhaps more surprising than GPs' support of the TCG was the support that this received from the Health Authority. The local nature of this initiative meant that it relied on Health Authority support for its instigation. This support was evident through the allocation of dedicated Health Authority staff (the TCG co-ordinator) to overseeing and supporting the work of the TCG, as well as the regular involvement of the highest level of management in TCG tasks⁶⁰. In addition, the incorporation of TCG members into existing commissioning structures, and the gradual reorganisation of these structures to reflect the collaboration were indicative of Health Authority support. I do not have direct data from Health Authority members accounting for such support, but my initial interview with the TCG chair did provide his perspective on the matter. He suggests that both the GPs and the Health Authority managers found more active GP involvement in such tasks to be quite beneficial.

TCG Chair - "In 1995, the Health Authority agreed to accept TCG on an advisory basis and this grew into a proper partnership on purchasing. This benefits the Health Authority as they now have a collective and corporate GP view, which was never available before. Previously, there had been criticism that the Health Authority had just sought the opinion of GPs who were most likely to agree with them. GPs are to some extent the users of the service and the Health Authority needs to communicate with the users in order to develop the service. In order to have strategy, there needs to be a partnership between GPs, the Health Authority and secondary services. The Health Authority was very keen to get a collective view from the GPs."

(Interview data)

Furthermore, observational data would suggest that there was a general recognition that the GPs were taking on a somewhat daunting task. The following extract is taken from the open meeting in which the scheme was being described by the TCG Chair to local GPs considering joining the project. He outlined the financial limitations involved in the Prescribing Incentive, and the associated transfer of 'risk management' to the TCG GPs.

Chair – "The cash limit on community prescribing is a key element to the project. The allocation for this year is known and the allocation for next year will be 'uplifted' by 7.7%. There will be an overspend for this year and this is seen as inevitable for next year. Therefore, a 'risk management assessment' has been put into place. Practice incentives will be available if we come in under the area wide allocation (actually

⁶⁰ The Health Authority Chief Executive and three Board Directors sat on the TCG board, and regularly attended the monthly board meeting.

allocation + 7.7% +2%). I believe that the target is difficult but not impossible – if we work together.

(Observational data)

In several subsequent meetings, various Health Authority Executive members publicly congratulated the TCG GPs for managing to curtail prescribing spending to the extent that they did. Previous prescribing overspends under the supervision of the Health Authority seem to indicate that the enforcement of clinical control had proven quite difficult; directly engaging GPs in the task was a new approach. The establishment of a collaborative prescribing incentive scheme facilitated the transfer of considerable extra work and responsibility from the Health Authority to local GPs. Moreover, the scheme aimed to entice GPs into taking greater interest in each other's practice, and seeking to take greater control over prescribing behaviour (both their own and that of their colleagues).

Perhaps even more importantly, the incentive scheme also necessitated that GPs should identify prescribing priorities, as well as express a willingness to sanction reduced spending levels in areas that were not collectively prioritised. Such prioritisation would prove essential in order to achieve the TCG's financial incentive. Thus, GPs' involvement in difficult and potentially controversial resource allocation decisions was officially established- perhaps paving the way for similar initiatives under PCGs.

4.3.2.2 Managing a service backlog

Another task that the Health Authority quickly delegated to the TCG was managing a backlog of cervical screening test results. The backlog was a result of a staff shortage in the local screening units; the district did not have the resources to process the number of slides constantly being submitted. Essentially, a centrally controlled resource shortage (of both funds to pay for testing and trained cytologists) had created a crisis in Casterdale that the Health Authority was having to manage. The Health Authority gave the TCG the task of finding a way to drastically reduce the number of slides being sent for screening until the existing backlog had been cleared. The TCG GPs were also charged with devising a workable structure, and subsequently communicating this to their GP colleagues.

Local managers described the TCG GPs as being in the best position to formulate a temporary, yet workable, solution that the local GP community would find acceptable. It appeared as if the commissioning GPs were being used as ‘sponsors’ for the initiative; their involvement provided the scheme with a level of legitimacy⁶¹. In taking on this role, the GPs alleviated the Health Authority of some responsibility for clearing the backlog. The Health Authority could claim to have done its part by engaging local GPs in finding a solution, and thus any ‘failure’ could be at least partially attributed to these GPs.

4.3.2.3 Winding-down and replacing fundholding initiatives

The previous two areas of work (controlling prescribing budgets and managing the cytology screening backlog) relate primarily to the TCG. Delegation relating more

⁶¹ This issue will be taken up later in this chapter.

directly to the new PCG structures was also evident. As previously outlined, PCGs were introduced as a replacement for the existing fundholding system. Outreach clinics in GP practices, treatment within the private sector, and the individual practice prioritisation of services such as physiotherapy and complementary medicine were all disbanded with the formation of PCGs. Although the White Paper clearly stated an intention to dismantle fundholding structures, however, it provided few details as to how this should be accomplished.

As outlined in Chapter 2, Casterdale GPs had generally been opposed to fundholding, and the vast majority had not joined the scheme. There were, however, several very disgruntled (soon to be) ex-fundholding practices within the district whose services had to be reformulated in line with the White Paper reforms. Perhaps in areas of the country where fundholding had been more prevalent, the replacement of fundholding structures was afforded greater priority by the Health Authority⁶². In Casterdale, however, the replacement of fundholding services with more 'equitable' structures, was left up to the individual PCGs. Furthermore, this task was delegated back up (from the PCGs) to a locally derived, meso-level professional collaborative structure - perhaps because of the history of GP collaboration, and the subsequent formation of a Collaborative Commissioning Mechanism (CCM) between PCGs. The PCG Chairs deemed the CCM to be the most appropriate body to take responsibility for this work, although this was potentially problematic because the CCM had evolved from the TCG that had once stood in direct opposition to fundholding.

⁶² In hindsight, this is an area where comparative data with other Health Authorities may have been very useful.

The following extract comes from a fairly heated discussion in a CCM meeting between PCG GPs and the Health Authority representative regarding replacing fundholding outreach clinics. The GPs were expressing difficulty in formulating acceptable replacements for fundholding structures. In the CCM meeting, the Health Authority representative does not engage in solving the issue, but rather reiterates that this work has been delegated to the PCGs, and that the Health Authority is anxious for results. In turn, the GP Chair disengages with resolving the task during the current meeting. The discussion on this issue was ended abruptly.

GP – “Each time we discuss this we get a specimen of different views on the ethics of outreach clinics.”

GP2 – “This issue has been devolved to PCGs”

Chair – “GP2 has made a good case for considering this service by service.”

Health Authority Representative – “The Health Authority want some firm ideas. They don’t want an in-depth discussion tomorrow.”

Chair – “If the Health Authority doesn’t have a firm position then they will have to accept that we need a discussion. Equity is the issue that is coming out loud and clear.”

(Collaborative Commissioning Meeting observation)

The Health Authority managers used delegation as a way to facilitate their decision-making procedures, while avoiding involvement in the conflict resulting from ex-fundholders’ resistance. By delegating this work to the PCGs, they were able to avoid becoming embroiled in the likely fundholder resistance and subsequent conflict. The Health Authority essentially abdicated responsibility by re-formulating this as a professional issue. The observational data revealed, however, that the CCM was not

necessarily perceived as having the authority to impose reforms on ex-fundholders⁶³.

Central/managerial guidance on the replacement of fundholding initiatives may, however, have provided the CCM's initiatives with legitimacy, and thus ultimately, authority.

4.3.2.4 The emerging role of GPs: Collegial Control

Beyond the tasks described above, by far the most substantial work involved in the newly emerging structures that I observed was a more active and official engagement in monitoring colleagues' practice. I will not, however, expand on this issue here as it is the focus of Chapter 5.

4.3.3 Structures supporting the status quo: power remains concentrated in the centre and with management

The official policy rhetoric of *The New NHS* described decentralisation as a major driving force for the reforms. In contrast, Casterdale's implementation process revealed several structures that firmly supported the maintenance of centralised control as administered through local management. The difficulties that GPs faced in 'taking' the control that was supposedly being passed to them were not always immediately apparent, but became increasingly so over the implementation period. The speed with which changes were being introduced, and the difficulty that GPs faced in attaining essential information both served to limit the extent to which GPs

⁶³ The geographic homogeneity of the fundholders (and their concentration largely within one PCG) would raise further complications for the CCM that will be taken up in Chapter 6.

could effectively take control. PCG configuration is one stark example of the effects of such limitations facing local professionals.

4.3.3.1 Timescale of change

With the formation of PCGs, significant areas of work and decision making were (at least officially) passed to local GPs and other board members. During the implementation process, however, my observations revealed that much of the work taken on by PCGs was still being firmly directed from the centre. Issues were not being identified locally, rather PCGs were being asked to advise and to make decisions on centrally determined agendas.

GPs who had become involved in the PCGs expressed dissatisfaction that the centrally directed work programme did not match their expectations; they asserted frustration over the sheer number of central directives, stating that these prevented them from spending time developing their own agendas. PCG boards had only limited time in which to conduct business (meetings were held once a month), and this time was being spent dealing with central initiatives, rather than locally identified concerns. The following extract from an interview with one of the PCG chairs illustrates his resentment.

PCG Chair - "A lot of the time at the moment is being taken up with 'givens' by the Health Authority. Documentation comes that says, 'We need a comment on this from PCGs'. So, there is quite a bit of that, which is seen to be quite intrusive. PCG boards see their role as being more bottom up – looking at what the community needs are and what the issues are locally and feeding those back into the system."

(Interview data)

The time scale for comments and decisions from PCGs also tended to be so short as to prevent GP board members from giving what they felt to be proper consideration to many issues. GPs questioned the possible value of their PCG contributions. Often, contributions could be little more than 'reflex' responses. One interview with a PCG chair provided his account of an extreme example of such timescale pressures, and the effects that such pressures put on the contributions of board members to decision making.

KC – “And then my final question is, the board meets once a month, what other meetings – you talked about the forum, but what else? Where do you see the work being done?”

PCG Chair – “In subgroups. All of these little subgroups that I have just mentioned will have a defined task and a timescale. Some of the work has to be done by (PCG Implementation Manager) and me on our own - to a tiny timescale. For instance, the HIMP wanted to know by the 30th of November what action we were prepared to take. So I took those five areas and worked on them a bit the weekend before last and sent them out to every member of the board on Monday and said, ‘I know that this is silly, but by next Monday I have to produce our agreed statement.’ So they produced their various themes, they were chased by the secretariat, I spent time on Monday collating it all together so that it went off to the Health Authority and then that collated form goes for discussion by the board next week.”

(Interview data)

It was not only GPs who recognised the challenges for effective GP involvement raised by such time pressures. Health Authority Implementation Managers also expressed frustration over the time pressures imposed in relation to establishing PCG structures. The managers presented their role as being to 'digest' the enormous amount of information so that the PCGs could then complete the required tasks in the time available. One implementation manager expressed concern that GPs would become disillusioned with their involvement in PCGs because the information that they received from the centre was overwhelming.

Implementation manager - "I think that what causes me the most frustration is that, and I think that you see it in the health service all of the time, we are not alone in this – there has been an awful lot of information sent out, some of it very detailed documents. And they are expecting turn around or comment within a couple of days. We are talking about people who already are working full time in their own specific fields being expected to spend an awful lot of their own time reading this information and digesting it and coming up with comments to be turned around in very short time scales. I think that it is very frustrating for me because the board sees it that – it is seen in two ways – it can see it that the information is being withheld from them so that they haven't got time to respond and therefore they are being shut out of the decision making processes, or they can see it that it is just an overload of work and it is ridiculous time scales where they cannot really give any proper background knowledge to the issues being put to them."

(Interview data)

The rhetoric of the White Paper outlines extensive GP involvement in directing the local management of care. These data suggest, however, that such involvement was limited by excessive allocation of tasks on the part of central government, matched with an extremely pressurised implementation time scale.

4.3.3.2 The Health Authority continues to control access to information

(A more extensive discussion of the tension resulting from access to information is presented in 5.4.3)

Greater levels of official involvement in resource allocation and the provision of care involved GPs in areas for which they previously had little concern. One such area was gathering information regarding GPs' practices and available resources.

The Casterdale GPs frequently expressed frustration over their difficulty in accessing necessary information for commissioning and PCG tasks. GPs emphasised that they were prevented from effectively undertaking the tasks that they had been delegated, because they lacked access to necessary information. Health Authorities held the information that GPs deemed to be important for the work that was being passed to PCGs: data at the level of the individual practices, historic spending data, referral information, and public health figures. Health Authorities also controlled the apparatus necessary to generate new data sets. The Health Authority's possession of such statistics was seen as a source of considerable power. GPs also described this as enabling the Health Authority to control the process of transferring responsibilities to the new structures.

The following extract from an observation of a TCG Forum meeting includes a description given by one of the GPs as to the difficulty that they experienced in attaining referral information from the Health Authority. Similar frustration was expressed in the meetings by other GPs.

(TCG Forum meeting October 1998)

GP1 – “Every meeting with the Public Health Director seems to go back to square one. They don’t see the point of feeding back information to GPs.”

(Discussion about the problems of specific management personalities. I ‘lifted my pen’.)

GP1 – “We don’t seem to be able to get the information out of the hospital system. The Health Authority executive don’t seem to see this as a very important thing to do.”

GP2 – “As the TCG we have had no authority over the people doing this.”
(Observational data)

GPs made mention of their inability to access essential information from the Health Authority in both meetings and interviews. The White Paper may have officially transferred responsibility for referral and prescribing behaviour to ‘local clinicians’ (as described in the policy rhetoric), but GPs often described themselves as powerless to access essential information. Thus, these GPs presented the delegation process as being relatively ineffective.

Furthermore, Health Authority managers were often able to use their privileged access to data sets to support their own clinical priorities, and sometimes to undermine those identified by the GPs. Health Authority suggestions about health needs were sometimes based on information unavailable to the TCG/PCG GPs. Essentially, the Health Authority managers were able to reject clinical ideas or opinions not in concordance with their own on the basis that these ideas lacked the relevant evidence base – an evidence base to which GPs were able to gain little or no access. The following extract is taken from an early PCG board meeting where a Health Authority staff member gave a presentation on ‘The National Service Initiative’, and elicited opinions from members of the PCG.

Health Authority staff member– “The National Service Initiative is just a document. What is important is what can be done about inequalities.....You need to determine your agenda in relation to the issues. There is a very high rate of heart disease in this PCG. We have identified that there is a group of people who get admitted to hospital but who are not labelled as having coronary heart disease. These patients get patchy care..... We are trying to get a feel for the sense of the problem within the PCG. We want to discover what the PCG wants to do.....I have come here today just to introduce some of the issues and the evidence base that is out there.”

(Observational data)

The Health Authority representative stated their intention as being to approach the PCGs in order to elicit ideas. Yet, he displayed pre-conceived notions (as illustrated in the data) as to the nature of pertinent local issues. He never asked the GPs whether they agreed (based upon their experience) that these were important issues, but rather

engaged the GPs only as far as to suggest how the problems already identified might be most effectively addressed.

Beyond lacking the necessary information to legitimise ideas that were not in line with those of the Health Authority (or were not being prioritised), GPs were described as ‘suffering’ from inexperience in relation to the managerial process. An interview with an implementation manager highlighted the amount of paperwork with which the new PCG boards were being faced– most of it dealing with unfamiliar processes and issues for the board members. The amount of data that the GPs were expected to digest, as well as their relative inexperience, limited the extent to which the PCGs could effectively inform and determine the decisions with which they were engaging . Even the Health Authority managers acknowledged this as being a pertinent difficulty for GPs.

Implementation Manager - “I think that they are getting very lost in all of the information that is being given to them at the moment. I think that the biggest problem is that they are having to make decisions without fully understanding the issues behind it.”

(Interview data)

The PCG GPs’ experience of their new role appeared to be significantly shaped both by a perceived lack of access to necessary information, as well as their position as novices, in relation to the tasks at hand.

4.3.3.3 Configuration

The process of determining the configuration of PCGs served as an illustration of the extent to which control over decisions was retained centrally. Soon after the release of the White Paper, many Casterdale GPs expressed a clear preference for the formation of a single PCG encompassing all the GPs in the Casterdale district. This model was closely based on the existing TCG structure. In both the interviews and the meetings, GPs seemed to assume that the structure of the existing The Commissioning Group (TCG) could essentially be superimposed onto the new PCGs. This assumption was based upon the idea that Casterdale GPs would be able to determine the shape of local structures because of pre-existing collaboration between the Health Authority and GPs, and the input of certain local GPs into pre-election Labour health policy.

The following extract is from the first open TCG meeting, in which one of the potential TCG members raised the issue of future PCG structures. The Chair expressed confidence that the advent of PCGs (which was already being anticipated) would not result in substantial structural change for the newly forming TCG. History would show that he was quite mistaken in relation to this issue.

GP on the floor notes that the White Paper talks about PCGs for populations of about 100,000. What therefore are the advantages of going with the PCG?

The Chair responds that the White Paper talks a great deal about local flexibility.

The urban concentration in Casterdale makes the proposed size of the TCG appropriate. "We are in a situation where the TCG gives us a bit of breathing space."

(Observational data)

Initially, TCG Forum members expressed confidence that the TCG model would be transformed into a PCG model. It soon became clear, however, that it was not inevitable (or even likely) that the TCG would simply be transformed into one very large PCG. In the months following the release of the White Paper, the Health Authority proposed alternative structures that mapped more closely to the Government's proposed configuration of PCGs with populations of about 100,000. At the same time, however, different possible configurations were still (at least officially) being considered through the consultation process with local stakeholders that was both arranged and facilitated by the Health Authority. I did not have access to the consultation process itself; the accounts contained within my data come from conversations on this topic at meetings, and descriptions given by both Health Authority staff and GPs.

GPs and managers offered conflicting accounts of the PCG configuration consultation process. GPs tended to focus on the strength of central prescription, and the extent to which pre-determined structures were imposed by the Health Authority. GPs' disappointment and disillusionment with the configuration process was clearly expressed in several meetings. The following extract is from the June TCG Forum, by which point it had become evident that the single "TCG type" PCG (favoured by many GPs), was unlikely be adopted.

The GPs are discussing their disappointment that their preferred structure for PCGs (retaining the existing structure based on the TCG) does not seem to be given consideration.⁶⁴

GP1 says that he doesn't think that there has been an adequate discussion of the configuration of PCGs to come to the conclusion that a consensus over their size cannot be reached. "There hasn't been a discussion of all of the options. The Government has been pushing for the [several] PCG model. The Health Authority Chief Executive has stifled any discussion of a large, all embracing PCG at the local meetings. We haven't had the discussion, but we are assuming that a large model isn't possible....."

GP2 says that the GPs that he had spoken to just wanted to stick with the TCG. But it had 'just come down' that this wasn't an option.

GP3 – "There will be a 'dog fight' tonight (at another local consultation meeting). I am concerned that there is a tribal attitude developing in Casterdale that may spread and affect all relations."

(Observational data)

For the TCG GPs, the decision to form several PCGs (instead of one) seemed to indicate that they had been ignored within the configuration process. Interviews with Health Authority staff, however, produced accounts of elaborate consultations with local stakeholders. The managers legitimised the new structures on the basis of this consultation.

⁶⁴ This was one instance in which I stopped recording 'verbatim', and instead took very brief notes.

Health Authority Implementation Manager - "It was one meeting that we had at a hotel. We had representatives from each Trust. We had representatives from each of the other local representative committees and we had representatives from the nursing profession... .. Anyway, that meeting – what we did was to present the options that had been put forward so far to people and then we invited them to go away into workshops and look at those options and look at what they could come up with. And what we ended up at the end of the day was not an agreement of what PCGs should be in Casterdale, but a sort of agreement on the principles behind a model for PCGs in Casterdale. We got that it was felt that local authority boundaries were important. We got this idea of centralising commissioning through something like the TCG but not necessarily the TCG – something similar. We got things like a size of around 100,000 was agreed to be about right – and that kind of thing. So that enabled us to think further about what sort of models we might want in Casterdale which resulted in the second consultation paper."

(Interview data)

In this manager's account of the consultation process, the adjustment of the size of the structure was not presented as necessarily in conflict with maintaining the essential nature of the TCG. Casterdale's population, however, meant that prioritising the size of PCGs would require the formation of several (rather than one) PCGs. It was clear from many of the GPs' statements that they perceived the formation of several PCGs to entail essentially abandoning the TCG model.

4.3.3 Summary

The experience of decentralising control within Casterdale was clearly not as simple as suggested in the official policy rhetoric.

It sometimes seemed that while GPs were being incorporated into decision making structures, they did not have sufficient support from central government to enable them to do the work effectively. The data revealed that time pressures, as well as a lack of both information and a managerial experience limited the effectiveness of GP participation in the new structures.

The New NHS entailed the delegation of decisions regarding ‘resource allocation’ (or rationing) to PCGs, while also maintaining centralised authority over spending levels. Responsibility for rationing was being moved outwards and downwards, but control over such measures was not subject to similar decentralisation. This appeared to be problematic for the GPs who choose to become GPs involved in PCG leadership.

Gillam and Coulter (1998) state that “The downside of budgetary control is the uncomfortable fact of having to live within cash limited budgets. Many general practitioners abhor the role of rationer, as it conflicts within their preferred role as patients’ advocate.” (pg. 1640). The new structures offered GPs increased influence over resource allocation decisions – but only on the condition that they took on responsibility for curbing their own and their colleagues’ spending. One GP, who worked as a Public Health Consultant for the Health Authority, identified this as a historical problem that was likely to continue.

Public Health Consultant - "What the GPs have never done and are going to have to do is to take responsibility for commissioning decisions. Now commissioning decisions mean saying 'no' as well as 'yes'."

(Interview data)

This GP asserted that the rationing element of PCG work would be particularly problematic for GPs because it clashed philosophically with the way that they had been trained to think about their role.

Public Health Consultant – "There are two philosophical schools of thought – Kant – the sort of theory that everything is in itself worthwhile. That you as a patient are so inherently worthwhile that whatever I can do for you is worth doing. And then there is Hume, the sort of.."

KC- "The greater good."

Public Health Consultant – " Exactly, and how do you balance those? You've got these two philosophical and perfectly acceptable philosophical streams coming into conflict within the GP. This is actually the problem."

Public Health Consultant - "But, GPs are not trained in any of the Hume view and this is the whole difficulty."

Public Health Consultant - "As a doctor you get trained very much in a Kantian view that the patient is all being, he is the only thing in front of you."

KC- "So you are saying this is pretty much a fundamental change to the work of a GP?"

Public Health Consultant- " mm.mm. It is so fundamental that I don't think people have grasped it, is my honest opinion. "

(Interview data)

Although official GP involvement in decision making structures did increase, the data also reveal complex power relationships on at least two trajectories: between local and centralised control, and between managerial and professional control. The policy seems to promote the idea of professional 'blame' rather than professional authority. Shapiro (1998) noted a similar dichotomy between a return to 'professional control' and ultimate control remaining with managers and politicians, and suggested that a true balance between these two sources of control is very difficult to maintain.

The data also revealed quite startling power differentials between the Health Authority and GPs in relation to several aspects of the decentralisation initiatives. Health Authority managers were able to use a rhetoric of 'decentralisation' or delegation of particular tasks as a way to reduce their involvement in difficult and potentially unpopular decisions. At the same time, managers were able to maintain control over large areas of work, and thus protecting their power within the emerging structures.

One of the complexities in considering the power relationships between the Health Authority and the PCGs is that we know so little about the power of the new PCGs⁶⁵. It is therefore difficult to establish the extent to which the power balance might be changing; it is impossible to measure any 'changes' to the control held by PCGs. We can, however, consider the way that the role of health authorities is changing, and how these changes are being interpreted by the different actors. Such analysis may provide insight into the power of the newly forming PCGs.

4.4 The role of the health authority: management on top of, alongside or within PCGs?

The advent of PCGs, and the accompanying rhetoric of delegating managerial tasks, raises questions as to the future role of health authorities. Local actors tended to frame the implementation period as a time of relative uncertainty, and there was a high level of speculation as to what Casterdale Health Authority's future role both would, and should, be. This speculation seemed to serve not only as simple conjecture, but also to establish possibly self-fulfilling notions of appropriate future power relationships.

4.4.1 The Health Authority's image of their continuing role: Health Authorities on top of PCGs (at least for now)

In Health Authority managers' accounts of the implementation of PCGs, the transfer of authority and responsibility for decision making to PCGs tended, perhaps not surprisingly, to be conceptualised in a relatively conservative manner. Managers

⁶⁵ (at the time of writing)

minimised the likelihood of meaningful change in control structures – at least in the near future.

One implementation manager interviewed soon after taking up his position (i.e. in the early days of the PCG shadow period), said that he felt that the board members of his PCG had over-optimistic ideas regarding how much power PCGs would take from health authorities. He proposed that GPs' interpretations were unrealistic, and presented an alternative image in which the Health Authority retained significant influence and control.

Implementation Manager – “‘I am tempted to say that there may be some assumptions perhaps, partly with the GPs on the boards, that after April (date for PCGs to ‘go live’) it will be their PCG. By that, I sort of mean that they think that the Health Authority own it at the moment. But, once it is live and real, they will be in power in some way. I am not sure that they are looking at it in quite the right way.”
(Interview data)

The perspective that the advent of PCGs would change little about the current power dynamics, at least initially, was also expressed by several other Health Authority managers. These accounts often seemed intended to legitimise the maintenance of managerial control through embracing the notion of the Health Authority providing essential ‘support’ for the PCGs. In the managerial accounts, the PCGs would not wrest control from health authorities both because they do not want it, and because they could not cope with such control were they to gain it.

Implementation Manager –“ ... We haven't had the guidance yet so we are only working on the assumptions that the PCGs will, in the first year, not want to be taking too much away from the Health Authority because they won't be able to cope with it. It is going to be so much. It is looking at devolving what is absolutely necessary, what has to be devolved, but keeping here the range of people to support each PCG.”
(Interview data)

The data also indicate a distinction between descriptions of control as being something that PCGs could 'take', and something that the Health Authority had the power to 'give'. The Health Authority's development of a conception of their control over the change process served to reinforce their power in relation to the newly forming PCGs. The following description given by one of the managers was based upon such an assumption; the Health Authority (rather than PCGs) would determine how quickly the transition of managerial roles will take place.

The Commissioning Group Manager –“Well, hopefully in the first year, in the structure meeting we will start talking about whether we devolve certain amounts of community services, small amounts of cash down to them (PCGs). But, if we do that, we have to be convinced that they have the staff to do it.”
(Interview data)

Health Authority managers presented themselves as being in control of the devolution of tasks to the PCGs. At the same time, they also portrayed the government as controlling the direction of changes, while they simply facilitated centrally formulated initiatives. Attributing such power to the government enabled managers to alleviate themselves of responsibility for unpopular rationing (resource allocation) decisions.

Managers' accounts often, however, contained contradictions as to whether they (the Health Authority) or central Government actually controlled the transition process. Such complexities resulted from managers continuing to prioritise their own importance to local decision making (thus to secure their position within the emerging structures), while also distancing themselves from potentially problematic restructuring. In the local realm, a continued assertion of themselves as more powerful than the newly emerging PCGs was most important for furthering the managers' own agenda.

4.4.2 GPs' ideas of a changing role for the Health Authority: Health Authorities alongside, underneath or within PCGs (as soon as possible)

The GPs involved with PCGs presented quite a different perspective of the future role of the Health Authority. They did not generally describe an indefinite maintenance of absolute managerial control for the Health Authority. The data did reveal, however, differences in opinion among GPs as to how quickly PCGs should seek to assume such responsibilities.

One of the PCG Chairs outlined his vision of the future as being one in which health authorities remained influential bodies, if only temporarily. This GP described the Health Authority as retaining responsibility for driving "*what is going to happen on the ground – that is, the Health Improvement Programme.*" He seemed relatively happy with a slow transition of power to PCGs, and to value the expertise held by the Health Authority in the areas of public health, performance management and finance. He did, however, also present the Health Authority's current dominance as a temporary measure.

PCG Chair – “I think that the long term view, from reading the Health Service Journal and elsewhere, it is likely that there will be health authority mergers. There will be a smaller number of health authorities and they will be focused on those tasks with your commissioning functions going to the primary care trusts.”

(Interview data)

This GP later described Casterdale Health Authority as being fairly over bearing, with a tendency to make decisions to which the PCGs were subsequently expected to agree. He provided the appointment process for the PCG Chief Executives as one example , and called for an immediate redress of any possible power imbalance. He concurred, however, that there was a necessary ‘learning curve’ for PCGs, for which the Health Authority’s existing expertise would be very valuable.

PCG Chair – “Casterdale, compared to some, is more of a controlling than a facilitative health authority. They might be unhappy to hear me say that, but if you go to other health authorities... ..they (the PCGs) have been much more involved in recruiting a chief executive. The other health authorities have taken a more ‘hands off’ approach. Whereas here, it is, to a certain extent the Health Authority is going to do everything for us and we are going to agree to it. I think that that will happen, I think that is fine in the shadow period. I am not uncomfortable or unhappy about it, and I think that as I said to (Casterdale Health Authority Chief Executive) , ‘I have got to recognise that doing a bit of commissioning for a few years, working on a bit of policy for a few years, might mean that I know a little bit about it, but that is a world away from actually doing it.’”

(Interview data)

This PCG Chair supported the idea of accountability being gradually transferred from the Health Authority to PCGs over several years. He presented himself as having limited managerial experience, and benefiting from this slow acquisition of new responsibilities. The Chair's perspective may be based upon a recognition that PCGs were, at this stage, relatively powerless to wrest control from the Health Authority. An account in which one temporarily acquiesces with a power imbalance may therefore offer the most potential for a positive self portrayal (if only temporarily).

Some of the GPs interviewed, however, produced accounts calling for a rapid transfer of control from managers to professionals. They produced more direct challenges to the idea that managers were 'experienced experts' who would provide leadership for the GP newcomers. Instead, these GPs portrayed the manager's role as being that of an auxiliary 'administrator' or 'facilitator', who should support, rather than lead, the GP board members. This position is quite forcefully asserted in the following interview extract.

GP – "Our model says that instead of having relatively inexperienced, distant Health Authority managers, we will have a lot of people with hundreds of years of experience between them, pottering around. It is the job of the Chief Executive (manager) to make sure that they potter around effectively. To make sure that they do what they are supposed to do. Make sure that it all adds up and that we don't have any gaps or overlap. It is the job of the Chair (GP) to make sure that the decisions that the board reaches about how it wants to use resources that make sense."

(Interview data)

The relative power of the Health Authority and the newly forming PCGs remained unclear during this transitional period. The official and legitimate role for the Health Authority within the newly 'decentralised' system had yet to be determined. The different actors therefore called upon various possible scenarios in line with their particular agendas or perspectives.

Health Authority managers presented themselves as controlling the pace of change – even though they abdicated responsibility for this change to the government. In so doing, managers were able to claim credit for securing the firm foundations for PCGs that the inexperienced and pressured professionals would not have been able to deliver. The continued role of the Health Authority would be to guide PCGs and to delegate work at a pace that would not overwhelm the new organisations, but would still satisfy the centrally set reform agenda.

The PCG GPs, on the other hand, outlined a more limited role for the Health Authority both during the transitional stage, and particularly once PCGs became more firmly established. The GPs described the transfer of authority to PCGs as serving to facilitate more effective health care provision – thus legitimising their dominance over managerial staff. The GPs generally predicted that in the future PCGs would incorporate managerial staff to work under, and in support of, professional decision makers. The GPs' accounts were based on the notion that decentralisation would eventually lead to PCGs (rather than health authorities) being in control of all local decision making. The GPs did, however, differ as to their preferred timeframe for such a transfer.

The different representations of the continuing role of the Casterdale Health Authority supported the agendas of various local actors. These accounts both reflected, and contributed to, complex and heterogeneous local understandings of decentralisation and managerial devolution. They also reflect a lack of consensus over the appropriate balance of power on both local/central and professional/managerial axes. In the next section, I will consider the extent to which collaboration was developed as a locally appropriate mediating factor – supported and deployed by the different actors as a means of creating and maintaining stability during a period of considerable uncertainty and flux.

4.5 Collaboration as a local adaptation of the decentralisation initiative

Locally co-ordinated collaboration between GPs, both before and after the formation of PCGs (as well as between professionals and managers), was an important aspect of professional involvement in decision making in Casterdale. This collaboration was largely focused around commissioning (or resource allocation) work, but was also applied to other areas, such as clinical governance. Collaboration was ‘popular’ with both GPs and Health Authority managers.

In the following section, I will examine the nature of the collaboration in relation to the decentralisation initiatives, and the use to which it was put by its proponents⁶⁶.

Although locally instigated collaboration received a high level of general support, I will also consider several instances in which actors sought to challenge the idea of such collaboration.

4.5.1 Collaboration pre-dated PCGs in Casterdale

The development of professional collaboration served as a cushioning factor in Casterdale's transition to PCGs –particularly in relation to the local operationalisation of decentralisation initiatives as outlined in the White Paper.

Casterdale's professional collaboration was based upon a relatively unique local history of co-operation. In this Health Authority district, GPs had generally adopted an oppositional stance to fundholding, and had worked with the Health Authority to construct alternative mechanisms for professional involvement in health care management. Both Casterdale GPs and Health Authority managers seemed to take pride in describing locally formulated GP involvement in the commissioning process that had developed into the Total Commissioning Group (TCG).

TCG membership was voluntary for GPs, yet two hundred and eighty eight GPs (nearly all of the GPs in Casterdale) chose to become members. The TCG was led and managed by a 'Forum' of sixteen GPs who were elected to represent their colleagues on commissioning structures. The GPs' experience with the TCG seemed to shape their perception of appropriate professional involvement in managerial work.

Casterdale GPs' general assent to joining the TCG suggests that, by and large, they conceived potential benefits from having representation on managerial and decision making structures. The TCG Chair described the size of the TCG Forum (which was eventually superseded by the PCG 'collaborative commissioning mechanism') as

⁶⁶ Collaboration will be discussed again in Chapter 6.

optimal; it allowed those who were interested in this aspect of work to become involved, while not requiring active involvement from GPs who were less keen. At the same time, the relatively uncontested nature of the TCG Forum elections (eighteen GPs ran for sixteen places) suggested that many GPs remained quite happy to delegate this work to others⁶⁷.

In Casterdale, a strong discourse of GP involvement in management preceded the introduction of PCGs. The GPs managed, however, to draw on the notion that 'normal' GPs did not want to be involved in such work. They raised the issue of colleagues' 'disengagement' with managerial tasks several times. One of the Forum members, for example, expressed concern about the possible efficacy of the communication process between the Forum and the other GP members when there was so little indication of any desire on the part of 'ordinary' GPs to have greater involvement in the actual commissioning process.

Once PCGs were established, some GPs who had previously had little involvement in managerial work did express uncertainty and concern as to whether they would be required to be more actively involved in the new structures. *The New NHS* outlined that PCG boards would be responsible for making decisions on behalf of their members, seemingly in anticipation of such concerns. As previously discussed, many GPs in Casterdale were familiar with a collaborative professional structures⁶⁸, and generally seemed to support the preservation of this model of working. Although these GPs were not successful in retaining a single PCG structure, they were able to

⁶⁷ These elections took place before my field work began. I learned about the elections in an early interview with one of the TCG GPs.

⁶⁸ With the exception of a handful of fundholding practices

establish locally formulated ‘upward’ delegation once PCG structures were in place. Furthermore, much like the TCG structure that preceded them, these collaborations were supported by both Health Authority managers and the majority of the more ‘politically active’ GPs. Joint working was eventually implemented in the form of the ‘Collaborative Commissioning Mechanism’, a PCG Chairs committee, a collaborative Clinical Governance committee, and several other ‘cross-PCG’ structures.

4.5.2 Collaboration as a means of reducing the workload of PCGs

Proponents of PCG collaboration tended to highlight the extent to which this mechanism would facilitate the accommodation of the massive increase in workload for the PCG GPs.

In one stakeholders’ meeting, a PCG Chair who had been involved in the GP commissioning structure since its establishment, presented collaboration as means by which to, “...*make life easier. It would be a disaster if we tried to do it for ourselves. Joint commissioning will work – we have already done it for a year.*” He did not, however, facilitate any open discussion about collaborative commissioning. Rather, he presented this as inevitable, and potentially very useful progress.

Collaboration between GPs, both before and after the formation of PCGs, was sometimes referred to as an essential means of both reducing the PCG workload, and facilitating enhanced professional influence over the decision-making process. One PCG chair described collaboration in the following way –

“There will still be a lot of stuff that can be done at a collaborative level and I feel that it is the only way to do it because of the sheer volume of work that needs to be done in order to commission appropriately. A single PCG won’t be able to tackle that.”

(Interview data)

Another PCG Chair echoed this point, *“I have got a clear view that nearly all of this is going to require collaboration because we ain’t got the time or the resources to do it any other way.”*

(Interview data)

Neither of these GPs engaged with the idea that the PCGs might choose not to take on the additional work being passed to them. They instead presented collaboration as being the way in which such work would be managed. GPs who had been involved in the TCG tended to portray the continuation of some kind of collaborative mechanism as being mere ‘common sense’. These GPs also tended to emphasise that involvement with the TCG had developed ‘expertise’ in dealing with the Health Authority and the Trusts that should be drawn upon. If collaborative structures were dissolved, PCGs would have to begin to build their own expertise, and this might prove to be a slow process. In addition, defending collaborative working allowed the GPs with ‘managerial experience’ to make (or protect) strong claims on positions of power. In this way, the GPs were potentially able to further demonstrate ‘valuable’ expertise.

GPs who had previously been involved in the TCG also defended the collaborative structure on the grounds that there was a general professional apathy in relation to this

type of administrative work. One PCG GP Chair suggested that he felt that the general lack of GP interest reflected a belief that *"They (Commissioning GPs) are doing a good job and I have got too much on my plate. Let them get on with it."* (Interview data) He countered, however, that the PCG work involved far more than commissioning, and suggested that once GPs realised that the PCG boards were making decisions that would directly affect their practice then their interest in such structures was likely to increase.

The Casterdale GPs presented collaboration as a means of increasing professional representation, without having to instigate a widespread modification of the professional role at the individual level. GPs have historically struggled to balance collective and individual notions of professionalism, a factor which would appear to have shaped the collaborative approach taken to PCGs in Casterdale (Clegg, 2000).

4.5.3 Collaboration as a means of gaining more control over PCGs

Health Authority managers and most GPs officially supported the development of collaborative structures between PCGs. Managerial support for collaboration did not, however, seem to reflect a particular interest in either the survival of existing bodies of expertise, or in the facilitation of collaborative professional working (and thus workload reduction). Rather, managers referred to the extent to which the collaboration was a means by which to facilitate the retention of a level of homogeneity between PCGs. One Health Authority manager described the benefits of PCG collaboration in relation to the possibility of 'fragmentation' between PCGs.

“We need to give PCGs a collaborative role or they will fragment. For lots of things it makes no sense to go [several different] ways”

(Interview data)

Managers also described collaborative structures as a means by which the newly formed organisations could be prevented from deviating too far from one another, or from taking on too much. Managers presented collaboration as a way to stop particular PCGs from ‘running before they could walk’, and their accounts conceptualised PCGs as inexperienced organisations for whom collaboration would be a valuable, transitional learning structure. Thus, collaboration might serve as a system of checks and balances, preventing PCGs from embarking on programmes of overly radical change. Moreover, collaborative structures would be forced to accommodate the perspectives of very different PCGs, thereby resulting in more ‘middle of the road’ kinds of developments.

The Chair of the Local Medical Committee (LMC) took a similar position to the Health Authority managers in relation to the potential benefits of the formulation of collaborative structures.

“So as to avoid duplication of effort, and people going off and heading in the wrong direction, there needs to be a coming together of the individuals leading those groups within the PCGs. So, in other words, we could have district wide groups.”

(Interview data)

The existing collaborative structures, and the individuals who led them, were familiar to Health Authority managers. Furthermore, the existing structures had not previously posed any great challenge to managerial authority. The managers outlined how local

GPs had gained managerial experience by working through the existing structures. Essentially, managers seemed to adopt PCG collaboration as a mechanism by which the effects of the 'decentralisation' initiative might be curbed, while still maintaining the benefits of GP participation in decision making. Collaboration was particularly attractive as it was a mechanism with which GPs were willing to comply.

4.5.4 Collaboration as overly restrictive and prescriptive

The development of collaboration between PCGs offered potential benefits for various local actors, and received relatively widespread local support. There were, however, a number of GPs who adopted an oppositional stance to collaboration. These GPs tended to be ex-fundholders, who had not been involved in previous 'collective' initiatives. Initially, these opponents were too isolated to pose any serious challenge to the collaborative mechanisms. Over time, however, the strength of their position increased quite significantly. Eventually, opposition to the collaborative measures built to such a level that it would seem likely that the PCGs will eventually have to deal with the issue more directly.

Some PCGs quickly identified areas over which they wished to take more localised control for commissioning. In such instances, the Collaborative Commissioning Mechanism (CCM) was presented as hindering local divergence. Physiotherapy was one area around which 'heated' discussion regarding standardisation occurred ; at least one of the PCGs asserted a desire and intention to regain PCG control for commissioning physiotherapy from the CCM as soon as possible. The issue was raised at several of the commissioning meetings (both in the form of the TCG and the

CCM), and clear discrepancies between GP practices with regards to physiotherapy referral patterns and resource allocation were revealed.

Some GPs who supported collaborative structures suggested that centralising commissioning could be very beneficial; they outlined the extent to which collaboration would allow inequalities in resource allocation to be reduced, and standardisation between practices to be attained. One of the GPs who was opposed to collaboration, however, countered this suggestion by informing the TCG that their PCG sought to gain direct control over physiotherapy as soon as possible. He defended this action on the basis that the PCG determined that they would be able to commission better services on their own. He also called upon the PCG's responsibility towards their own patients. The position that he adopted seemed to stand in direct opposition to principles of inter-PCG collaboration.

GP1 – “In my PCG, it is strongly felt that physiotherapy should not be centrally commissioned.”

GP2 – “The amount of money (allocated to physiotherapy), or the way of commissioning?”

GP1 – “It depends on whether it is seen as an improvement. There is a feeling that better value for money might come from Hospital X (not the primary provider for the district) - and in the end it comes down to value for money.”

GP3 – “This is a brave new world.”

GP4 – “This is a key issue. This argument will be repeated hundreds of times about different issues.”

(Observational data)

If this perspective were to be widely adopted, only collaboration that was judged to be the ‘best deal’ for each of the PCGs would be seen as appropriate. The alternative (collective) perspective was that the best ‘deal’ is the one that provides the most care for the greatest number of people – across PCGs rather than simply within them. GPs have traditionally been expected to prioritise the needs of their individual patient/s. The model of professional involvement in managerial tasks is, however, built upon a more collectivist perspective. Thus, the data begin to reveal basic contradictions within *The New NHS*.

Most of the ex-fundholding GPs were allocated to a single PCG. It was representatives of this PCG who tended to voice the loudest opposition to the philosophy and practice of collaborative working. They were particularly vocal in their opposition to structured collaboration around commissioning. The Chair of this PCG openly described his desire to move towards independence, with more ‘grass roots’ control, with the intention of moving the power for decision making towards the PCG, rather than with a collaborative structure. The Chair made reference to fundholding experience to promote his alternative model of PCGs; he suggests that this was what the government intended in introducing the new structures.

PCG Chair - “In Casterdale there is a huge voice and pressure being applied for all of commissioning to be the same for every board, which will account for probably 2/3 of the budget. The money for commissioning will go into a central lobby – of which

there will be representatives from our PCG. That will be central, and I think that it will be very difficult to have something different in our PCG than any of the others. That is the impression that I have got in the couple of months. I hope that I am wrong, because I think that if we succeed, every PCG should be like a total funding consortium⁶⁹, and that of course is what the government wanted. For each PCG to become a trust on its own. And that will be a complete trust, hiring its own staff, making its own rules and all of the rest of it."

(Interview data)

Several of the non-fundholding GPs also expressed reservations about collaboration. These GPs noted the ability of the Health Authority to use collaboration to preserve status quo, while retaining their authority.

PCG Chair - "If the authority insists on powerful, dictatorial leadership then two of the PCGs will move very quickly to Primary Care Trusts separately – (the largely fundholding one) and this one."

(Interview data)

Collaboration between PCGs was a complex process that accentuated some of the difficulties faced by individual PCGs. Attempts to reach a consensus between the PCGs over resource allocation and clinical protocols (two pre-existing aspects of collaborative work) proved particularly contentious. The extent to which collaboration was seen to originate with the PCGs, rather than the Health Authority, however, appeared to be central to whether collaborative measures were generally accepted by the GPs.

⁶⁹ An advanced form of fundholding

4.5.5 Collaboration as compromise or informal resistance?

Collaboration between PCGs was an influential aspect of PCG implementation within Casterdale. It built upon pre-existing relationships, and was supported by both Health Authority managers and many of the GPs.

For Health Authority managers, collaboration seemed to provide a level of security from PCG ‘fragmentation’. This issue was particularly important in relation to the common belief that the transition to PCTs (Primary Care Trusts) would result in a merger of existing PCGs. By focusing on possible future PCG mergers, managers were able to reconstruct a central role for the Health Authority, rather than dwell on any seeming dissolution at the present time. One Health Authority manager described the transition as follows,

“If we go five or ten years down the line, if the PCGs become Trusts and we perhaps have PCGs amalgamating to become Trusts, for example if the city ones merged, then the Health Authority would take on a much more central role again.”

(Interview data)

For many of the GPs, collaboration facilitated their representation within management structures, while also allowing them to maintain an acceptable balance of managerial and more traditional, clinical tasks. Collaboration also facilitated a certain level of non-participation in management for many GPs, without requiring active resistance to the reform measures. Thus, through a collaborative approach, GPs could expand their professional domain into the managerial realm without necessarily sacrificing their identity as clinically focused.

Collaboration may represent 'the path of least resistance' for PCG implementation in Casterdale. It effectively allowed the continuation of locally derived structures that were comfortable for both Health Authority managers, and most of the local GPs. Collaboration can, however, also be seen as a form of informal resistance - similar to that identified by Hughes and Griffiths (1999).

The New NHS clearly outlines a 'decentralisation' initiative based upon PCGs with patient populations of about one hundred thousand. This structure initially faced GP resistance because of pre-existing, locally derived acceptable means of working based on managerial and professional co-operation across the entire district. The Health Authority chose not to formally defend the locally formulated structure, but rather to establish several PCGs as outlined in the White Paper, and subsequent documentation. Furthermore, local GPs were unsuccessful in resisting its dissolution into smaller PCGs.

Through the collaborative structures, however, the GPs were able to effectively reformulate the TCG (though slightly amended) around the PCG structures. Without resorting to official resistance, the GPs effectively re-established the TCG under a new name, with a slightly different structure and membership. In addition, this process was supported by management - seemingly because it was seen to protect the workable status quo. The Casterdale structures outwardly complied with the Government initiative. Upon closer analysis, however, they also largely 'sidestepped' the central reforms, in favour of a locally developed structure.

Opposition to collaboration on the part of some (mainly ex-fundholding) GPs, who had not been involved in the existing power sharing structures between the TCG and the Health Authority, proved quite justified. Collaboration, particularly in relation to commissioning, facilitated the maintenance of the TCG's philosophy. Fundholding GPs, however, tended not to support this perspective, but had rather had worked to use the internal market to benefit their own patients. They were unlikely to be satisfied with the CCM's decisions. Ex-fundholders described PCGs as a way of building on the strengths of fundholding⁷⁰, rather than collaborative commissioning. It was apparent that they were frustrated by the use of collaboration to prevent change that they conceived to be progressive. It also seemed unlikely that the PCGs would become strong, independent organisations (at least along post-fundholding lines) while the CCM existed.

I began this section by claiming that collaboration was widely supported by both GPs and local managers. I suggested that both recognised potential to further particular agendas within a collaborative framework. I then provided examples in which PCG GPs expressed caution or open opposition to inter-PCG collaboration. The future of collaboration in Casterdale was not determined during the period of data collection. Rather, it appeared that these locally formulated structures would face ever more difficult challenges. It remained unclear whether either the Health Authority or the former TCG GPs would have the power to prevent PCG divergence in the face of strengthening GP opposition. Collaboration seemed to hang on a delicate balance of 'goodwill', which if disturbed, could leave an unworkable arrangement.

⁷⁰ This model was adopted in other areas of the country where fundholding had been predominant.

4.6 The interaction between decentralisation and central guidance

The local reception of central guidance relating to the implementation of reform initiatives is an important part of the reform process. Government guidelines and guidance around reform implementation can be conceptualised as mechanisms through which additional centralised control can be inserted into a reform process. Hughes and Griffiths' (1999) research on the implementation of the 1990 reforms (particularly the process of contracting between health authorities and trusts) also highlighted the importance of central direction to NHS reform initiatives.

"We argue that, although a rhetorical appeal to a de-centralised decision making is a highly salient feature of the NHS reforms, one should not underestimate the continuing importance of central direction, or the ability of managers and professionals to subvert the new market discourses in much the same way they did the bureaucratic discourses of the pre-reform health service." (Hughes and Griffiths, 1999: 72)

Hughes and Griffiths suggest that although the reform rhetoric prioritised 'decentralisation', action continued to be shaped 'at a distance' through centralised pressures and externally determined, material constraints. They incorporate Foucault's (1979) notion of 'governmentality' to explain such control mechanisms; the Government will portray power as becoming increasingly decentralised, while also claiming to maintain (or even strengthen) centralised structures of control and influence. Thus, central departments are able to retain control by creating incentives to push members in specific directions. The reforms enable the Government to 'steer' the NHS 'at a distance', or even to 'act' at a distance'. These central structures may

not be particularly visible; they rather facilitate a mix of autonomy and regulation based on quite subtle forms of central direction.

Subtle centralised control is potentially more powerful than more overt bureaucratic mechanisms. Bennett and Ferlie (1994) propose that although communications from the Department of Health are called 'guidance', they tend to be treated as 'tablets of stone' by those who receive them at the health authority level. Both the Casterdale GPs and Health Authority managers described an expectation of prescriptive central guidance in relation to *The New NHS*. Participants drew comparisons with previous reform initiatives that were seen as very prescriptive, and predicted that similar central direction would soon arrive for the present reforms. In addition to such descriptions, my observations also suggest that the anticipation of central guidance shaped interaction during the preparation period for PCGs.

Central guidance relating to *The New NHS* was a topic of considerable disagreement and contradiction in Casterdale. Although the anticipation of guidance seemed to unify most of the local actors, once guidance was received, reactions were quite varied. Some people said that the guidance was too prescriptive, while others lamented the lack of Government direction. Differences of opinion were also expressed as to the value of particular pieces of guidance. In the following sections, I will briefly explore both the relationship between central guidance and decentralised decision making, and the seeming disparity of opinion as to whether this reform process suffered from either too much or too little central instruction.

4.6.1 Guidance as mediated by the Health Authority proves Problematic

The influence of central guidance in the formulation of the early PCG agendas emerged as an area of considerable dissatisfaction for many of the PCG GPs. One of the PCG Chairs expressed his displeasure through his predictions of likely government involvement in the development of Primary Care Trusts

Chair - "They (the Government) were quite prescriptive on PCGs. One wouldn't think that they would be any less prescriptive on PCTs. I am quite distrusting of this Government. I don't think that they allow enough for local flexibility."

(Interview data)

It was also clear that the position that the Health Authority held as 'the mediator' of centrally produced guidance contributed to GPs' sense of dissatisfaction. The Health Authority was charged with receiving, interpreting and implementing central guidelines in their locality. Thus, managers held a position of some influence, from which they were able to assert continued local control. Health Authority managers were able to call upon central guidance to justify the central position that they occupied in formulating early the PCG agendas.

Health Authority domination of these agendas did not, however, go unchallenged. PCG configuration was a topic for which the power of central control as employed through local structures was particularly pertinent. The extent to which centralised control as enacted by the Health Authority was problematised, however, differed

between clinicians and managers. Health Authority managers tended to negate the significance of their control over early PCG meetings.

Health Authority implementation manager – “The agenda has been very full of Health Authority directed business, just about setting the PCG up in a corporate, proper sort of way, adopting reasonable financial arrangements, making sure that we have got a draft constitution that we feel comfortable with.”

(Interview data)

The Commissioning Co-ordinator produced a description of the consultation process with GPs and nurses over PCG configuration. In this account, he highlighted constraints as stemming from Department of Health guidance, and described the extent to which the Health Authority's hands were 'tied' by such guidance. In so doing, he distanced himself from the unpopular structural decision that was taken.

Health Authority manager – “We are sort of co-ordinating the whole business of the PCG, and how we get it up and running. The first thing was to have these consultation meetings..... We just finished those and the paper is now going to go to the Health Authority (board meeting) with our recommendations as to how we want to split it up. We want to put it into (several) PCGs based upon the local authority boundaries and we are going to separate off the commissioning function into this overarching collaborative commissioning arrangement – and that is what the TCG will become.”

KC – “So, the discussion that happened at the TCG forum of another option of a massive PCG – did that just come to nothing outside of the forum? It seemed as if there was quite a lot of support there.”

Health Authority manager – “There was. Initially we had the option alongside our (several) PCG split in the paper and we decided to pull it out because we finally consented that they (Department of Health) were going to tell us that there was no way that a big one (PCG) is going to go ahead. We were more or less told that we were going to have to break it down. We never actually consulted the other GPs about that and I think that that is where the TCG became a little annoyed.”

(Interview data)

The Health Authority manager emphasised the overarching power of central government, thus justifying the Health Authority's seemingly controlling behaviour. He presented the idea that the government was unlikely to accept the locally proffered model of a single district-wide PCG as part of an account of why the Health Authority dismissed this option. In 'consultation' meetings such as the one described, the Health Authority only presented the GPs with the Health Authority's preferred scenario.

The exclusion of alternative models seems to have spurred anger, resentment and mistrust among GPs. The TCG GPs' dissatisfaction with the decision to curtail the structural options for PCGs was forcibly expressed in the June 1998 Forum. The discussion at this meeting was fairly furious (keeping up with field notes was difficult at times), and enticed opinions from several GPs. The GPs formulated resistance to the dominant model proposed by the government (through the Health Authority)

based on a lack of widespread professional consultation. A contradiction, however, arose when the GPs proposed both that their colleagues were uninformed of the available choices, and also claimed to fear a growing division among GPs over such choices.

(June TCG Forum)

The TCG Chair said that it has been very difficult to present a 'TCG view'. There are different opinions in the TCG as the most appropriate future system.

GP2 says that he doesn't think that there has been an adequate discussion of it to come to the conclusion that there is no consensus. There hasn't been a discussion of all of the options. This is because the government has been pushing for the multiple PCG model. He said that [the Health Authority Chief Executive] had stifled any discussion of a large PCG at [one of the consultation meetings]. "There hasn't been a discussion at the TCG but we have assumed that there can't be a big PCG."

GP3 – "Should GPs be balloted?"

GP4 - "The GPs need to be informed. They haven't been given the opportunity to choose one big PCG." He proposed telling GPs of the various options and then putting it to a ballot. "They should be given the choice of a large PCG with reformatted constituent representations, locality sensitivity."

GP5 – "The GPs that he had spoken to just wanted to stick with the TCG. It just came down that this wasn't an option. The GPs want to hold on to the TCG."

The TCG Chair remarked that they might just be able to hang on to the TCG.

GP6 - “ There will be a ‘dog fight’ tonight. I am concerned over a ‘tribal attitude’ developing in Casterdale which would spread to affect all relations.”

GP7 - “We need to know what GPs think. We need to ballot them. We might have a national ballot. We still need to know what the GPs in Casterdale think.”

GP4 – “If you look at our history, we have stood against the government before. Why can’t we keep on doing what we have proved works?”

(Observational data)

The GPs vocalised their intention to actively resist the Health Authority’s imposition of one configuration. This opposition, however, never seemed to materialise – at least on the formal level. The stance taken by the Chair in this discussion was particularly interesting. The discussion began with the Chair defending his decision not to push for representation of a TCG model of configuration (a single PCG). He did not challenge the GPs who asserted that this was their preferred model, but rather suggested that the TCG might continue regardless of the imposition of a multi-PCG structure. It seems likely that the idea of an overarching collaborative structure had already been formulated between the Chair and Health Authority managers, and that the Chair appreciated a ‘way around’ this through informal channels.

4.6.2 Central Guidance as supportive and/or facilitative

Centralised control was not, however, always presented in a negative light. In some instances, the actors chose to focus on the potential for central guidance to be supportive, rather than overly prescriptive. Occasionally, both GPs and managers drew upon central guidance to lend support to local decisions. Furthermore, PCG GPs sometimes appeared to actively seek central guidance in relation to the resource allocation decisions with which they were faced.

The issue of Viagra⁷¹ prescribing was one such example; Viagra prescribing was informally raised at a commissioning meeting. The government had announced that it would produce national guidelines on the issue. The production of guidelines as to who should be prescribed this newly available drug potentially fell into the domain of the CCM. The GPs discussed the potential financial implications of including Viagra on the NHS formulary. They expressed a desire for the government to publicly embrace the difficult 'rationing' decision, and considerable relief that this appeared to be occurring.

(Field notes from a commissioning meeting)

Before the meeting officially started there was light-hearted discussion between the members about the announcement that the government would not support the prescription of Viagra on the NHS until national guidelines had been produced. This decision was in line with the proposal put forward by Casterdale Health Authority (to which the Commissioning Chair had contributed). The government is delaying the prescription of Viagra until it can calculate the potential costs.

⁷¹ A newly released, highly publicized impotence treatment.

One GP commented, “That’s alright. As long as the government makes this kind of decision from time to time and doesn’t always leave it up to us.”

(Observational data)

Thus, central guidance served at least two purposes. In some cases, its existence allowed local professionals to reduce their responsibility for potentially difficult decisions with which they were faced. It is also possible that when GPs were able to demonstrate that local decisions were in concordance with central guidelines, such local decisions attained greater legitimacy.

In some cases, managers presented central guidance as being a crucial ‘filter’ for locally directed work. They took the position that the demands placed on the NHS by the local population were potentially insatiable⁷², and central guidelines can therefore provide a useful framework to which those charged with making resource allocation decisions may refer. Thus, central guidance may be used as a mechanism to absolve local actors of responsibility for the ‘rationing’ with which they are engaged. One implementation manager gave a positive portrayal of central guidance, based upon the need for such a ‘project’ filter.

Implementation manager – “I think that one of the fears (about the new initiatives) is that everything gets so diluted that nothing happens in actual fact. You have got to pick out some priorities and hone in on those... .. We have got some national priorities set down – like cancer and A&E [Accident and Emergency], from which

⁷² See Chapter 2

you identify a couple in the first year to focus in on. So there is some guidance and a framework in there.”

(Interview data)

As GPs' involvement in rationing work increased, it seemed ever more likely that they would make similar use of central guidance.

4.6.3 Central Guidance is Influential Even in its Absence

One particularly paradoxical aspect of central guidance's influence on the decentralisation of decision making was the apparent effect of even an *absence* of such guidance. One might assume that an absence of central guidance would leave local actors relatively empowered. My data suggest, however, that the lack of *anticipated* guidance often paralysed decentralised decision making structures.

Concern over the delayed arrival of anticipated central guidance was expressed from the highest level. Casterdale Health Authority's Chief Executive explicitly referred to this delay in his account of the difficulties faced during the formation of PCGs. The issue of central guidelines was deemed to be crucial at this juncture; he claimed that whenever anticipated guidelines were not produced, this served to disable the peripheral structures.

Health Authority Chief Executive - “As far as I can see, all of the national thinking is about what needs to be done to support PCGs and get them in place and the timetables for all of the guidelines of that are slipping anyway. We have had to advertise for lay members of PCG boards before we can even say if there is going to

be any remuneration. GPs have had to put themselves forward without knowing what the remuneration is. There is national guidance on functions of PCGs that is not out yet. So again, it is all cart before horse – structures before functions. It is all the wrong way around – and that is just in the PCG arena.” (Interview data)

It sometimes seemed that saying nothing actually gave the government significant influence. In Casterdale, decisions were sometimes either not taken or implemented on the basis that local actors were waiting for the arrival of central guidance. Actors expressed concern over possible divergence from central instructions that would eventually arrive.

Local actors were, however, also able to usefully engage with the lack of central guidance to account for their difficulties and frustrations in relation to the implementation of change. Both GPs and Health Authority managers utilised unexpected delays in central guidance (for instance, details as to the role of a PCG board member), to shift attention over frustrations from the local to the central level. One Health Authority manager made reference to a lack of central guidance as part of his explanation for the PCGs’ lack of progress.

Health Authority manager - “So, there is quite a lot of guidance still to come down telling us what GPs and the Boards will need to be doing in their first few months. And yet they are meeting as a group a week on Monday and this guidance is still not here. So that is causing problems, really. Not just for us, but for the GPs who then ring us and say, ‘How can we be expected to sign up for something when we don’t really know what is involved?’”

(Interview data)

One Health Authority implementation manager used the lack of guidance as a prompt to discuss the important supporting role adopted by the Health Authority.

Health Authority Implementation Manager - "It would have helped to have a bit more direction, rather than having to do a bit of interpretation about these kind of things.

We often go to other health authorities and say, 'What have you done here?' Not because we are behind the times, but because we need to share these ideas."

KC – "There hasn't been an official forum for that?"

Health Authority Implementation Manager – "No, not really. It is a case of – no, there hasn't. I think that that is something about politicians saying, 'Yeah. We will let these organisations develop locally, naturally. We don't want to upset the GPs too much. Definitely, because we want them on board.' I think that that is about it. Also because they haven't got a clue about how things actually run – operate. It is very difficult. We have got lots of guidance that isn't directive – whereas previous guidance was much more, 'This is what you will do. How, when and how much you will pay people to be here. Much more directive."

(Interview data)

This manager presented the 'void' around central guidance as a government strategy to ensure that potentially resistant GPs remain content. Releasing detailed plans for PCGs might have proved problematic; essentially, the 'devil may be in the details' Furthermore, once guidance is issued, discontented GPs might have found ways to manipulate these to serve their own objectives. The Chair of the LMC also expressed

concern that GPs would be able to refrain from becoming involved in the PCGs because the 'role' expectations had not yet been clearly defined⁷³.

*Chief Executive of the LMC - "At the moment, elections are supposed to be taking place for GP members etc. and they are all saying, 'Before we stand for election we want a clear idea of what the responsibilities are, the time commitments and remuneration. We are taking time out of our practices and our practices want to know.....' Really they are looking for a level, an indication that there has been a degree of commitment to the whole process via some sort of remuneration package for GPs who want to do this kind of work."*⁷⁴

(Interview data)

Whether the problem was in the production of details, or in the particular details themselves, GPs did seem able to avoid committing to the new structures by claiming that they could not determine whether involvement would be feasible. This 'distancing' was, however, a relatively temporary phenomenon. The local GPs general acquiesced to the new structures over time.

4.6.4 Summary

The interaction between centralised control (through the production and distribution of guidance) and the stated objective of embarking on a process of decentralisation, created contradictions within the data. The availability and influence of central guidance was an area of both dispute and complexity in Casterdale. Descriptions of

⁷³ I do not have direct input from GPs because at this point it was difficult to identify who would be involved in the PCGs. Most TCG GPs were still openly distancing themselves from it. GPs that I did interview at the time did not directly engage with this issue.

‘mounds of paperwork’ from the centre were quite common, as were protestations that ‘we have been left in the dark’ – on the part of both the GPs and the Health Authority managers. Thus, there was confusion as to whether central guidance either facilitated or prohibited decentralisation. Central guidance over the decentralisation process was, however, clearly a salient issue, and one that was called upon by both managers and GPs as a tangible means of expressing general dissatisfaction with the reform process.

4.7 The use of decentralisation towards competing agendas

I began this chapter by asserting that decentralisation was central to the rhetoric of *The New NHS*. I then illustrated the extent to which decentralisation was not as simple or homogeneous as implied by the policy, but was rather quite a complicated process.

Flynn’s (1992) analysis of the 1974 NHS reorganisation has strong resonance with my data from the 1997 reforms. Flynn concluded that the 1974 changes were based on the principle of delegating responsibility to the local level while also strengthening centralised accountability structures. Much like *The New NHS*, the 1974 reforms stressed local consensus and decision-making, while simultaneously attempting to establish a vertical hierarchy of command. I was, however, concerned that in applying this analysis to the 1997 measures, the discovery of continual centralised control might lead me to reify government influence, and thus to underestimate the agency of local actors.

⁷⁴ In fact GPs did sign up for positions on PCG boards before they knew what the remuneration

Hughes and Griffiths (1999) warn against the potential to mistakenly dismiss influential local actors as puppets, *“The image of remote control, together with the Foucauldian overlay added by some writers who use this framework, means that while agency is attributed to the overseeing policy makers who pull the strings, the actors who make the system work are portrayed as being largely swept along by forces outside of their control.”* (Hughes and Griffiths, 1999: 89). Indeed, a portrayal of local actors as mere recipients of policy does not sit easily with my data.

Hughes and Griffiths (1999; 89) also suggest that, *“What both the action and steering frameworks seem to be missing is a proper analysis of the discretionary power of lower participants, and of their ability to develop coping strategies to manage disturbances coming from outside the local organisation.”* The influence and interaction of local actors will be discussed in more detail in the following chapters. I will however, end this chapter by attempting to unravel the coexistence of both decentralisation and augmented centralised control in Casterdale. I will give consideration to the ways in which the government, Health Authority managers, and local professionals (GPs) were able to shape the implementation of the decentralisation initiative, and to use this process to serve their own agendas.

4.7.1 The Government Agenda

4.7.1.1 Decentralisation as a means of reducing state involvement in resource allocation decisions

As outlined, the implementation of *The New NHS* decentralisation initiatives reflected more than a simple reallocation of tasks. The advent of *The New NHS* did not result in GPs 'taking charge' of decision making through the newly forming PCGs. Rather, while certain specific tasks were delegated, others remained firmly under centralised control. PCGs were quickly charged with greater involvement in resource allocation, budgetary control, the transition from fundholding and managing service backlogs – none of which were easy tasks. PCGs were, however, given little control over the speed at which change occurred, nor access to information upon which to direct future change. Rather, the particular tasks that were highlighted in the decentralisation process, and the means by which this work was conducted reflected underlying power structures and competing agendas within Casterdale.

The government's engagement with 'selective' decentralisation can be understood as an attempt to shift attention for difficult and potentially unpopular decisions away from the centre, and onto local professionals. Decentralisation was one means by which to gain GPs' assent to participate in such decision making. It also seemed to encourage GPs to take on more responsibility for identifying care priorities and resource allocation (rationing); thus securing professional influence over the commissioning process.

"Deregulation and decentralization can also take political heat off of the central government." (Light 1999c p. 22)

Light's (1999c) analysis of previous NHS reforms conceptualises decentralisation as a means by which politicians can rid themselves of the pressure of cost containment, and to shift responsibility onto providers through initiatives such as managed

competition. He proposes that the creation of the internal market in health care can be seen as an attempt to reformulate government services and responsibilities by deflecting blame for refusing to fund costly services away from politicians towards private contractors.

It was common for the GPs not to conceptualise the restructuring as a professional opportunity, but rather as political delegation of unattractive managerial jobs to local professionals. Furthermore, this perception of the delegation was shared by local managers. Managers described considerable tension among the GPs relating to the decentralisation of particular tasks. In describing GPs' initial reluctance to take part in the newly formed PCGs, one of the implementation managers suggested that the GPs felt that they were being given responsibility for difficult decisions that the government sought to avoid. One manager's account actually suggests a degree of local alliance between GPs and managers in relation to this issue.

Implementation Manager - "So, I think that some of them sense that they are being led along a little bit by the government, who are actually being quite clever and dumping a lot of problems and decision making with the GPs and letting them sort it all out. Which is quite a good trick – if they can pull it off. So, naturally some of them (GPs) are uneasy about that. They are concerned about the board being held accountable by their patients for rationing, that instead of blaming the government or whoever, they will actually be able to blame your own GP or the board, or whatever – because they have done it. There is enormous concern for this."

(Interview data)

Everett Hughes' (1971) notion of the centrality of designation of 'dirty work' within occupational settings has resonance for these data. Hughes' theory acknowledged that for every area of work there are certain tasks that will be deemed to be less desirable than others. Tasks may be unappealing because they involve physically repugnant elements, or because they are morally or philosophically disagreeable. Wherein one is associated with 'dirty work', so this may tarnish the individual's professional standing simply by association. Dirty work is allied with professional stigma. 'Dirty work' is avoided wherever possible – often through reassignment of such tasks to other groups in the setting. More powerful actors distance themselves from tasks that are deemed to be vile in some way, and attempt to define these tasks as the work of others – and as such, a moral division of labour develops within occupational settings.

'Dirty work' is not, however, an objective notion. One of the complexities of this idea is the fact that one group's dirty work may not be seen as such by others. Essentially, dirty work often entails those tasks which are essential to the area of work, but that do not contribute to the improvement of one's professional standing, or indeed, potentially serve to harm it. Although there are tasks that will be seen as generally undesirable, there are others that will be treated as dirty by one occupational group, but taken on by another (Emerson and Pollner, 1976; Strong, 1980).

The designation of 'dirty work' status to a particular task reflects the perspective of the worker as much as it does the task itself (Shaw and Middleton, under review). For certain occupations, a task will be central to its stated purpose, and thus will not be considered to be 'dirty' – while for others, this same task is peripheral to the image of the occupation through which power and status is granted, and thus it is designated as

being dirty. In medical settings, the work assigned to nurses (physical cleaning of the patient, for example) is often called upon as an example of such work.. Doctors are the more powerful group in this setting, and thus they have as little involvement in such tasks as possible. It could be, however, that in the same setting, bureaucratic paper work would also be considered to be 'dirty'.

One example of such a task that is relevant to this study is the status of financial management tasks within health care. Doctors have traditionally sought professional standing through dissociating themselves with any notion of financial accountability for their medical decisions. In this way, doctors have been able to claim a 'purity' for their work – all decisions resting on the determination of the best course of action for the individual patient, rather than any resource restrictions.

On the other hand, financial management tasks are the core task of NHS managers. The managers conceptualise such tasks as being central to establishing an efficient and effective service and providing adequate care for the greatest number of people. Their occupational standing results largely from the extent to which they are involved in making such decisions and thus shaping the nature of care itself. The same task is both 'dirty' and 'clean' depending on the occupational perspective from which it is considered.

This notion of 'dirty work' may be one perspective from which the delegation of only certain tasks to the PCGs may be understood. The power relationship between those who delegate (central Government and the local Health Authorities) and those to whom they delegate (local professionals) in this instance remains very complex; it was not clear that the GPs were impeded by the transferral of this 'dirty work'.

Rather, while local financial management tasks have negative connotations for politicians, the data also suggest that the GPs were actually able to engage the new tasks in their efforts of professional expansion. Still – the tasks were constructed as dirty work by both GPs and local managers.

In commissioning meetings, the GPs often made statements about resisting the excessive transfer of work that was associated with their expanding managerial role. Calls to serve on more committees, to devote more time to commissioning work, and the expectation that GPs would ‘chair’ (or take responsibility for) new structures, were all presented as contentious issues. The following extract comes from a commissioning meeting in which the GPs discovered that the Health Authority Public Health department was considering withdrawing its involvement in the ‘commissioning’ structures (where specific agreements were made with secondary providers). The GPs expressed concern about being delegated additional work; nobody voiced excitement over the potential for this new work to expand their professional jurisdiction, nor the seeming possibility to reduce Health Authority ‘interference’.

Health Authority Representative on the TCG– “Public Health was considering withdrawing from the programmes (commissioning structures)”.

GP1 (very animated) – “Imagine the programmes working without the Public Health people and how much work the GPs would be expected to do. This seems to be the level of GP involvement that is being required.”

GP2 – “Why haven’t GPs been involved in the decision making process?”

Health Authority Representative on the TCG – “The Director hasn’t officially said that they are withdrawing support.”

GP2 – “They have no right to do that anyway!”

GP1 – “I turned up at a Programme meeting and found that I was expected to chair it.”

GP3 – “We are not being paid to do this. We are paid for two sessions a week and that is not what is intended from two sessions a week.”

(Observational data)

In this episode, the GPs are discussing the local managers attempts to use the decentralization initiative as an opportunity to distance themselves from responsibility over more challenging financial managerial structures (the programmes). While the GPs may have seized upon the idea of the delegation of *control* of financial decision making, the management of such work was clearly still conceptualized as dirty work which was the domain of management, rather than professionals. Furthermore, management’s attempt to delegate tasks to professionals seemed to be received very badly – presumably because it infringed the hierarchical status delegation in this setting.

4.7.1.2 Decentralisation as a means by which to legitimise change to the public and the profession

During the decentralisation process, the reform rhetoric frequently emphasised the role played by the PCG GPs in identifying local needs that could then be applied to, or targeted within, national initiatives. Clinicians were identified as ‘local experts’ who would usefully inform the decision making processes. GPs were given extended roles as ‘advisors’ to local policy, thus facilitating more ‘wise’ and well-informed decisions. The incorporation of GP ‘experts’ into the decision-making may have been one way to add weight to decisions that continued to be essentially controlled by local management and central policy makers.

TCG GPs were often called upon to offer advice and opinion for ‘difficult’ decisions, as described by one of the TCG Forum members before the formation of PCGs.

TCG GP – “There are various things that come from the Health Authority for comment. They say, ‘We would like your opinion on this.’ So, various things come for comment – for direction. Quite a lot of the problem areas are around big new investment decisions – about which there is likely to be some controversy.”

(Interview data)

In order for *The New NHS* to be successful, it was important not only that the public be convinced that the changes were potentially beneficial, but also that the support and the collaboration of the profession itself be gained. The inclusion of GPs within the newly forming structures was also one possible means by which to gain support for the changes from those who would be bound by them; this is key to the effectiveness of any set of rules (Freidson, 1975). GPs who demonstrated some willingness to become involved in PCGs were incorporated, and were useful in gaining the support and co-operation of their colleagues

Several GPs expressed uncertainty that their input amounted to more than a 'rubber stamping' of decisions taken by managers and politicians; PCG GPs commented that they felt as if they were being used by both central Government and the Health Authority. During the consultation period, GPs expressed particular concern about taking on responsibility and then being blamed for decisions that they would be 'forced' into making.

Larson (1977: 199) suggests that, "*Internally, expertise is implicitly proposed as a legitimation for the hierarchical structure of authority of the modern organization; professionalism, in turn, functions as an internalised mechanism for the control of the subordinate expert.*" Including professionals within the official decision taking structure may have been an effective control mechanism. By incorporating professional expertise, rather than challenging it, the policy makers were able to tap a more effective means through which to gain a compliant workforce, as well as a critical policy endorsement. Thus, the nature of such inclusion may have essentially prevented professionals from substantially influencing the decisions being taken.

4.7.2 The Managerial Agenda

The decentralisation initiative provided a two-fold opportunity to further the managerial agenda. It both subtly challenged GPs' power in relation to decision making, and also reinforced managerial influence in such tasks. Managers were able to define GPs as being inexperienced in relation to managerial matters, and therefore in need of managerial support. Such depictions may have served to slightly undermine professional prowess in favour of managerial competence. They also

provided management with a keystone position during the transition – and perhaps beyond.

Health Authority managers used this period of change and transition to entrench their own influence

. Managers formulated powerful accounts in which GPs were presented as being incapable of handling the increased workload necessitated by the creation of PCGs, and rather highlighted managerial expertise in such matters. Furthermore, managers emphasised the necessity to ‘spoon feed’ information and decision making to PCGs. Thus, these accounts defined managers as the only actors capable of grounding the decisions and the work that was demanded of PCGs. Through such portraits, managers positioned themselves as ‘kingmakers’ – indispensable and powerful, without being in the limelight, and without necessarily being held to account for the decisions being taken.

The following extract is taken from an interview with a senior Health Authority manager in which he described his work to provide the PCG GPs with prototypical solutions for the decisions with which they are being faced. The provision of such support places the manager in a potentially influential position; they define (or at least direct) the possible scenarios with which the PCGs will engage. The manager calls upon the GPs’ lack of experience in such matters to both justify and protect management’s mediating role.

Health Authority Manager – “The way that I am tending to work at the moment is that we do something here and put together a prototype model for discussion.

Because if we just go with a blank sheet to the PCGs at the moment, without the

knowledge....They know me and they know that I am not out to question their competence. They accept us really giving them ideas."

(Interview data)

Moreover, to the extent that managers retained a level of local responsibility (at least temporarily) for service provision, the incorporation of professionals in managerial work was a potentially effective approach to controlling costs (Elston, 1991). *"The main strategies general managers envisage for incorporating doctors, as identified by Scrivens, are to increase clinicians' participation in resource-use decisions in committees or to devolve budgets to clinicians. The latter has the potential to enhance collective clinical control over resource use, even if encroaching on the technical autonomy of some of the individual doctors."* (1991: 73) Thus, effective professional incorporation would reflect well on managerial performance, thus reducing the likelihood of loss of control.

Health Authority managers were faced with a reform initiative that potentially challenged their continued influence, and control over the management of health care for the local population. The local managers were, however, able to identify and mobilise several perspectives from which the process could be moulded to protect, and thus serve, their own agenda.

4.7.3 The Professional Agenda

GPs did not present a homogeneous position in relation to the new reforms, nor was it easy to identify a unified professional agenda. Indeed, increased professional involvement in managerialism raises significant questions for general practice - both

in terms of clinical freedom, and with regards to their 'defining' role as patients' advocate.

While it was clear that PCG GPs were being increasingly called upon to take part in drawing up and enforcing budgets, it was less clear just how the "power sharing" between the Health Authority and the PCGs would be established. Involvement in a process, and even responsibility for it, does not necessarily indicate that one has authority over it. The White Paper stated that the new structures would be monitored by the Health Authorities, but provided little about how this system should work. Neither was it particularly apparent from the fieldwork that any significant transfer of authority to GPs was actually occurring.

The augmented managerial role taken on by some GPs through the reforms may have actually served to widen existing professional chasms. Involvement in *The New NHS* seems likely to have alienated some 'political' GPs from their colleagues⁷⁵. The 'active' GPs demonstrated that it was possible for professionals to adopt a positive perspective towards the delegation of resource allocation tasks, which can be interpreted as a means of increasing GP control over health care provision, thus potentially boosting GPs' influence. The power to allocate resources is also important for determining one's capacity for organisational influence (Flynn, 1992: 47)⁷⁶.

⁷⁵ It was however, such 'political' GPs who were most easily identifiable in the setting, and it was therefore they who became the focus of my research. When I refer to a 'professional agenda', I therefore primarily refer to the agenda put forward by GPs who were actively engaged in political and managerial realms.

⁷⁶ Flynn however concluded that power was being displaced from professional providers, and was being claimed by managers.

GPs who had taken on managerial work often emphasised that such bureaucratic endeavours were not the type of work with which other GPs were eager to engage. They took care to state that they did not feel that such tasks should necessarily be central to the work of GPs, and also claimed that it was beneficial to all GPs that someone take on this work. In an interview during the early days of the TCG, one PCG Chair claimed that the new structure would allow the majority of GPs in Casterdale to,

PCG Chair - "Ignore the job of managing and commissioning secondary services and get on with the work of clinical practice. At the same time, there is GP input into the decision making process and there is a system of accountability and a local structure. Elections are held annually, which allows GPs that want to be involved in this side of health care to be so."

(Interview data)

The 'politically active' GPs claimed that their colleagues tended to present involvement in 'managerial' and 'resource allocation' work as being outside the realm of 'real' medicine for which they were trained. These GPs asserted that most GPs sought to distance themselves from managerialism, and were relatively happy to accept collective structures that enabled them to avoid involvement in the 'dirty work' of health care management. One PCG GP Chair provided a succinct account of why GPs might perceive managerial work to be unattractive.

PCG Chair – "I can tell you something about how it affects the practice of a practitioner who has chosen to be involved. It has an adverse effect. It takes an interested, motivated, energetic GP out of the practice where he or she is doing things

that they are good at and is trained to do well. It puts in his place a locum who may or may not know the practice, the district, the patients. This is a very serious downside, and I don't think that anyone has tried to quantify that. So general practice will suffer where GPs get involved in PCGs."

(Interview data)

The construction of such a portrayal of commissioning and PCG tasks can be understood through reference to Hughes' (1971) analysis of 'dirty work'. The 'political' GPs in Casterdale depicted managerial work as 'peripheral', and yielding little discernible return. The extent to which the work was actually 'dirty' beyond such a professional portrayal, however, remains an unresolved issue. It may be that the work was actually quite rewarding. These GPs may have produced negative portrayals both in order to provide continued support for the traditional power base of the 'altruistic' GP, and to reduce the likelihood that they would face challenges from colleagues for positions that actually served as an empowering expansion of their clinical role.

The GPs who engaged in managerial work defined themselves as 'enthusiasts'; they did this work because they wanted to, rather than for personal or economic reward. This portrayal allowed them to justify their decision to engage with 'dirty' managerial work within the pre-existing altruistic professional framework. A notion of vocation was invoked. Their involvement in managerial work did not reflect a betrayal of 'true' general practice, but rather enthusiasm and dedication to one's work.

TCG GP – “.....I would say that that goes for most of the GPs involved in the TCG – they are in it largely because of interest.So most of the people are to some extent enthusiasts.....You can get away with using enthusiasts because they are usually putting in more hours than you are paying them for.”

(Interview data)

The GPs tended to present their involvement in the TCG (and subsequently PCGs) as being either like a ‘hobby’, or as a slight ‘eccentricity’. This protected them from the criticism that they were neglecting the core ‘altruistic’, caring work of doctoring in favour of involvement in managerial tasks. The ‘new’ work was also kept clearly separate from the realm of ‘everyday’ clinical practice, thus demonstrating the appropriate limited engagement of the majority of their GP colleagues.

The complex interaction of the professional agenda and the reform initiative is a theme that runs throughout my analysis. It is touched upon in the other data chapters - as well as the discussion. I have provided a few examples of potential positive applications of the decentralisation initiative for the profession in order to counter notions of local disempowerment, and overstated images of government and managerial power.

The data certainly seem to lend support to a multi-factorial notion of professional control⁷⁷ that does not sit particularly easily with more traditional accounts of professional dominance. Professional control was being moulded and enhanced by increasing clinical involvement in decision making. At the same time, professionals’

power is commonly conceptualised as resting on principles of clinical autonomy, to which these reforms presented significant challenges.

4.8 Summary

Decentralisation is an increasingly important concept in understanding the way that large organisations operate. Deal and Kennedy (1988) proposed that decentralisation would shape future organisational forms (p. 178). Autonomous units with some financial interest in the organisation's success would become the standard organisational structure, rather than more traditional forms.

Recent NHS reforms, including *The New NHS*, have sometimes been conceived as attempts to reduce central control in favour of empowering capable local actors.

Larson (1977: 192), however, presented a more critical analysis of decentralisation by asserting that increasingly complex bureaucracies⁷⁸ will attempt to routinise operations and to increase central control – thus reducing the discretion of subordinates. My data similarly support the notion that this particular decentralisation initiative does not entail such a straightforward transfer of power as the policy suggests.

Larson contends that while organisations overtly work to decentralise, they also seek to lengthen the chain of command. This leads to an increased subdivision of labour, and delegation of authority. The focus on professionalisation in organisational

⁷⁷ Such as Elston's [1991] model of professional control having separate financial, political and clinical components

⁷⁸ The appropriateness of the notion of 'bureaucracy' for understanding the operation of the NHS will be taken up in the discussion chapter.

restructuring is one way of making increasing levels of discretion more predictable. According to Larson, by adopting such a position, decentralisation can be accomplished without the loss of centralised control. Thus, professionalism can be relied upon as a means of limiting individuals' 'abuse' of the lack of direct supervision.

My data also suggest, however, that decentralisation is not a straightforward process. Rather, there may rather be an 'optimal' level of decentralisation from the point of view of the policy makers, local health care managers, and professionals. Politicians may seek to limit decentralisation in order to maintain central control and common standards of quality and efficiency. Managers, in turn, may seek to defend the status quo (in which they were relatively powerful) by supporting a move to a 'meso' level of control, rather than complete dissemination to localised PCG structures. It would also appear that GPs may recognise a potential to increase their influence at the policy table – both locally and nationally. The data from Casterdale illustrate that GPs do not simply strive for an ever increasing managerial role; a careful examination of GPs' engagement with decentralisation reveals a contention for a specified level of involvement, rather than taking on ever more managerial authority.

Hughes and Dingwall (1990) concluded that the 'decentralisation' initiatives of the 1990 reforms had done little to weaken the power of the State. The decentralisation process described in the policy document was never operationalised. Power remained centralised, thus the new language of 'contracts' was largely metaphoric. The new system simply imposed a more specific rule-based structure that was more difficult to enforce.

My consideration of the decentralisation process within *The New NHS* would suggest certain modifications to Hughes and Dingwall's analysis. Certainly, these data support the notion that regardless of the rhetoric, decentralisation is not a straightforward transfer of power from the government to local professionals. Many centralised structures were retained, and those that were newly created largely supported the continuation of centralised and managerial authority over the decision making procedures. The Casterdale data also reveal that decentralisation had some unquestionable effect on the local power structures. The role of local professionals in decision making has been formalised through delegation of augmented responsibility for resource allocation to the new PCGs. I suggest that decentralisation is best considered in relation to a continuum of control structures. The implementation of decentralisation initiatives can be understood as resulting from different actors seeking to impose and protect their 'optimal' position along this continuum.

The policy makers sought greater professional involvement to both legitimise and deliver centrally driven policy. At the same time, they feared losing control to the periphery. Local managers faced the task of operationalising policy. They worked to counterbalance the emphasis placed on professional involvement within the policy by maintaining strong local control. Furthermore, GPs sought greater influence at the policy making table, but largely wished to avoid both distancing themselves from their 'altruistic' claim for professional power, as well being saddled with responsibility for resourcing decisions over which they had little control.

The local actors in Casterdale had, at least for the time being, utilised existing local structures to achieve a workable compromise - collaborative structures both within

and between PCGs. These compromises were (on some level) supported by both local managers and GPs⁷⁹. I have also suggested that the new structures may serve to further the government agenda of using professionals to both legitimise decisions as well as (as I will go on to discuss in the next chapter) to deliver the compliance of their colleagues.

I have spent considerable time discussing the extent to which the decentralisation initiatives augment centralised control. GPs and Health Authority managers initially displayed considerable concern as to how the new 'building blocks', as outlined in the White Paper, would be established. Setting aside any initial resistance to the PCGs, however, the collaborative mechanisms developed locally do not seem so very different from those implemented by the GPs themselves before the White Paper. The government's recommendations on population size and local authority 'co-terminosity' were presented as being in direct conflict with established local ways of working. GPs and managers were, however, effectively able to re-establish the district-wide structure that was supposedly superseded by the present reforms, in the form of the Collaborative Commissioning Mechanism, and other cross-PCG structures.

The development of such local collaborations might lead one to judge the present reforms to have failed in relation to local implementation of the policy objectives. Little 'real' change to local structures or professional involvement would seem to have occurred. It may, however, be more appropriate to focus instead on the extent to which the policy rhetoric has been incorporated into established and successful

⁷⁹ The limited duration of this research prevents me from considering whether central government will

local ways of working. In terms of outcome, the reform initiatives have been successful in that they did not invoke significant professional resistance. In the long term, this shift in ideological foundations may have a greater impact than one might predict. It may, therefore, be inaccurate to portray this process of decentralisation as the great empowerment of local medical professionals (particularly GPs). It would also seem erroneous to assume that such changes will necessarily serve as serious challenges to GPs' pre-existing power and status.

5. 'The New NHS' as a Means of Strengthening Clinical Control

"The present UK government intends to manage the performance of the 'New NHS'; the word performance appeared 88 times in its recent white paper." (McColl et al: 1998, 1354)

5.1 Introduction

In this chapter, I aim to unpack some of the 'clinical control' elements set out in *The New NHS*; particularly those that emerged as being central to GPs' involvement in the local implementation of the reform initiatives.

I begin with a brief history of policy initiatives structured to strengthen clinical and financial control within the NHS. I do not intend to repeat the history already presented in Chapter Two, but rather to identify possible stimuli for the reform's focus on increasing and formalising control structures within the NHS. I will present this primarily because it has shaped choices relating to the current measures - both what the initiatives should entail, and the means by which they should be implemented.

I will then suggest ways in which the official reform 'rhetoric' may have been specifically designed to placate professionals, and possibly entice their co-operation. Analytic histories of the NHS frequently highlight the level of professional resistance to government attempts to increase control over medical care, and such histories tend

to blame reform initiatives' limited success on professional resistance. In the 1997 initiative, greater control over medical practice was entwined with other objectives that were likely to be more palatable to the profession. The official objectives of the White Paper provided a level of contextualisation that facilitated favourable local interpretation of the proposed changes. Effective reforms need both public and professional support; both are potentially significant for the successful implementation of the new instruments of command throughout the NHS.

This chapter will primarily be concerned with issues related to and resulting from the stated official policy objectives. I will discuss the local implementation of the control measures, and the factors that shaped and constrained their development, and will focus on the local implementation of the clinical control initiatives. The Casterdale data provide evidence of the capacity of local actors (particularly GPs) to mould official objectives into workable structures. I will also consider several factors that seemed to limit the GPs' ability to shape objectives of greater control to serve their own professional agenda.

In the final part of the chapter, I will contemplate the lasting effects of the application of the policy objectives within the local context. To what extent will these control initiatives shape the continued relationship between the state and general practitioners, and how might this affect the future of the NHS?

5.2 A Perceived Need for Greater Government Control Over the NHS

When the NHS was established, a system was created whereby control over the new institution was largely placed in the hands of the medical profession (see Chapter 2). Kelly and Glover (1996) propose that such professional self-regulation was a founding principle of the NHS; the idea being that each 'little society' (professional organisation) would internally (and largely informally) self regulate, thus reducing the need for costly external surveillance.

Professional autonomy was thus core to the regulation of clinical practice in the NHS. Under a system that would survive relatively undisturbed until the mid 1980s (Harrison and Ahmad, 2000), doctors were responsible for monitoring the practice of one another, as well as being diligent about maintaining high personal standards of practice. Yet, specialist doctors working in hospitals were subject to little or no external supervision, and general practitioners worked as independent, self-employed contractors to the NHS with only very vague descriptions as to their duties.

By officially engaging the medical profession in controlling its own practice the government was able to expand its own jurisdiction without significantly increasing its own workload (Halliday, 1987). The government was essentially relieved from having to monitor this part of its domain by putting trusted and skilled individuals in charge of regulating the system. This system of professionally mediated control also had the perverse effect of greatly limiting the government's power to control what went on in the NHS. Politicians were expected to refrain from speculating about what was (or was not) appropriate care, and thus related costs essentially remained outside government control. The government's role was largely limited to setting budget levels, within which medical professionals were expected to operate. To this extent, the NHS has traditionally been state supported and professionally mediated. These

budgets were, however, regularly exceeded. Unfortunately, insufficient consideration has been given to the benefits accrued by the government from being able to avoid active and daily regulation of clinical practice (see Chapter 2 for a discussion of the inherent contradictions between public expectations of the NHS and its capacity).

The notion of ‘clinical governance’ was central to the official rhetoric of *The New NHS* reform initiative, and was defined as being ‘*a framework through which NHS organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence and clinical care will flourish*’. (NHS Executive 1998: 33, in Harrison and Ahmad, 2000: 135). A reform that sets out to establish assurances regarding the quality and efficiency of practice is relatively simple for policy makers to defend to the public, particularly within the increasingly dominant paradigm of evidence-based medicine (Ber, Horstman, Plass, and van Heusden, 2000). The implementation of such measures is a more complex matter.

5.2.1 A rhetorical shift from curbing costs to assuring quality

“The government is determined that the services and treatment that patients receive across the NHS should be based on the best value for money (clinical and cost effectiveness). At present there are unjustifiable variations in the application of evidence on clinical and cost-effectiveness.” (The New NHS, 56)

Since its formation in 1948, the ‘real’ cost of providing health care through the NHS has been rising steadily. In 1948, it was estimated that the NHS would cost approximately £176 million per annum, whereas the actual cost of providing health

care during the initial year was £437 million. By 2000, NHS spending had risen to £49.3 billion (though this figure would need to be adjusted for inflation for an actual comparison). Even at this level, a significant shortfall between patient expectations and available resources remains, such that the 2000 budget included promises to increase spending on the NHS to 7.6% of the GDP within four years (Ferriman, 2000).

Unlike previous reform measures, however, *The New NHS* rhetoric was not focused upon the idea that increasing control within the NHS would also serve to control costs. The objectives of *The New NHS* and other recent policies were not framed in terms of controlling spending levels, but rather in relation to the use to which resources are being put, and (increasingly) on the demonstrated efficacy of the service. These priorities would seem to reflect a recognition by policy makers that there is greater public support for the NHS, and for improved services, than for reduced spending.

There have been numerous approaches to increasing control over the NHS (Grabosky, 1997). At one extreme is a system based upon complete professional self-regulation; no active government involvement is deemed to be necessary. At the other extreme is a system of complete government control.

Traditionally, the role played by the medical profession in delivering such control has been given priority (Ashburner, 1996). Doctors have been expected to monitor their own and colleagues' practice under the auspices of altruistic professionalism. Professional control has, in turn, formed the basis for control throughout the system. The initiatives outlined in *The New NHS* do not inherently break with such a position.

The rhetoric of *The New NHS* explicates potential inefficiencies and inequalities in the currently disjointed system – rather than the cost implications of professional control. The establishment of professional autonomy without the concurrent installation of professional responsibility for maintaining budgets had seemingly created a tenuous chain between the ‘purchasers’ of health care (the Government) and the ‘providers’ (the medical profession) in relation to controlling spending. Policy makers, however, also seem to have appreciated some advantages in prescribing the existing ‘internal’ system of professional control to be ineffective in delivering cost efficient health care provision.

5.2.2 Controlling Standards of Care

Historically, the state’s role in controlling the cost of care has been considerable when compared to its role in determining how care is actually delivered. Daily practice has been deemed to be largely the realm of professional control and discretion. This system allowed the government to expand its jurisdiction without significantly increasing its own workload, by officially engaging the established medical profession in monitoring its own practice.

Since its establishment through an act of Parliament in 1858, the General Medical Council (GMC) has been, and remains the core formal, regulatory body within the NHS (Moran and Wood, 1993). The GMC is officially responsible for setting and regulating the ethical standards of the medical profession. The GMC is primarily controlled ‘internally’ by the medical profession. Its control mechanism consists of both formal and informal collegial monitoring, with increasing recognition of

continual peer review as an essential part of fully developed professionalism (Freidson, 1990: 444).

Thus, the medical profession has been granted relative autonomy essentially in exchange for ensuring the maintenance of a certain level of quality (MacDonald, 1995; Allsop, 1995). The state has, however, always held a key position in both the establishment and continuation of such power⁸⁰. Since professional autonomy cannot be either 'demanded' or 'taken', but must always be granted, professionals will, to a certain extent, always be dependent on the state for continued jurisdiction.

A successful claim to professionalism requires that clients believe that such professional autonomy is warranted (Wolinsky, 1993). Public support is somewhat dependent on public recognition of effective mechanisms of professional regulation. Indeed, trust has been identified as an important factor in the effectiveness of individual client/professional relationships (Starr: 1982), and patient trust in the profession as a collective (as well as in single, individual practitioners) has been found to be crucial to professional control.

There have recently been several dramatic and well publicised instances where the GMC, and the British medical regulatory system in general, appear to have failed to control medical practice. These 'failures' have served to raise doubts as to the appropriate level of public trust in the ability of the medical profession to self-regulate. In one instance, surgeons were identified who had been allowed to continue to perform cardiac surgery on infants after colleagues had expressed concern about

standards of practice, and survival rates from such procedures had been found to be abnormally low. In another case, an NHS gynaecologist was found to have been allowed to continue practising several years after his performance had been identified as erratic and unsatisfactory by both colleagues and patients.

A further dramatic illustration of the negligence of the current regulatory system has, however, come from within primary care. In 1999, an NHS GP was found guilty of murdering fifteen of his own patients under the guise of treatment, and is currently under suspicion of causing over one hundred other deaths. His practice had escaped detection (or at least serious consideration) by colleagues for many years, calling into question the possible effectiveness of a 'collegial' safety net (Freidson, 1983). These cases were given significant media attention, and the issue of clinical control has become a popular topic of debate, with growing public support for strengthened systems of professional regulation⁸¹.

Any profession that is perceived to be failing to deliver effective self-regulation is in jeopardy of forfeiting its autonomous status, because alternative control mechanisms are likely to gain support. Thus, it may be preferable for a profession to acquiesce with initiatives designed to demonstrate more effective self-regulation, rather than to actively resist any external 'interference' in the defence of professionalism (Berg, Horstman, Plass and van Heusden, 2000).

⁸⁰ The relationship between the state and clientele over granting autonomy to NHS doctors is complex. For a fuller discussion see Chapter 2.

⁸¹ All reform initiatives that are framed as challenges to existing systems of professionally mediated systems of clinical regulation may be conceived as responses to an increasing public sensitivity to risk in this area (Alaszewski et al, 1998 in Harrison and Ahmad, 2000: 140).

The relationship between clinical autonomy and the establishment and maintenance of a successful claim to professionalism is complex (Ashburner, 1995), and the effect of a loss of occupational autonomy for the continued power of a profession has been an issue of considerable academic debate. There are ongoing disagreements as to whether autonomy over clinical practice (or its equivalent) is at the heart of any and all professional claims. Harrison and Shultz (1989) argue that autonomy is central to any successful professional claim, and this position also shapes theories of professionalism put forward by Freidson (1984, 1985, 1986). Wolinsky (1988), on the other hand, would counter that the notion of practice autonomy has been overstated in academic debate regarding professional power. Indeed, the existing sociological literature around the history of the NHS has demonstrated that British doctors have successfully defended their professional power and status through a succession of reforms that were perceived as posing serious challenges to their autonomy (Kelly and Glover, 1996).

5.2.3 Summary

Hughes and Allen (1993) propose that most NHS reform initiatives can be understood as government attempts to impose common structures of accountability and control. Klein's (1995) assertion that the 1991 reforms worked to persuade the medical profession to "accept more collective responsibility for the way in which individual members exercise their craft" (p. 323) is in line with such a position. Establishing collective accountability may serve as an effective mechanism by which to ensure that individual professionals will be motivated to control their own clinical practice (Scott, 1982: 235). The sociological literature suggests that this is more likely to be effective than previous NHS reform initiatives that introduced (and strengthened)

managerial control by increasing the role and authority of full-time managers. Such measures tended to result in greater professional resistance, and achieved quite limited results (Klein: 1995). More recent measures have attempted to incorporate the profession into strengthened systems of control, and to promote managerialism from within the medical profession (Berg et al, 2000)⁸².

5.3 How are the reform initiatives presented within ‘*The New NHS*’?

“The Government certainly doesn’t want to see reorganisation for the sake of it.”

(The New NHS, 50)

“This White Paper marks a watershed for the NHS. It sets a clear direction for the NHS as a modern and dependable service. But it will not mean a wholesale structural upheaval, generating costs and disruption that get in the way of patient care.” (The New NHS, 76).

Structural reorganisations have been a fairly regular feature since the formation of the NHS in 1948, and much of the rhetoric of The New NHS seems to address perceived widespread ‘reform fatigue’ on the part of both medical professionals and the general public. The White Paper acknowledges that previous reforms have brought disruption, and promises that this reform will not simply be more change for change’s sake, but will result in ‘real’ progress.

⁸² A theme that will be discussed in more detail in chapter 6

Beyond the assertion that the reform initiatives would bring about real and meaningful change, the policy makers had a fairly challenging 'sales pitch' to deliver. As already discussed, the NHS has historically been conceptualised as being controlled primarily by (or through) the medical profession. Thus, any reforms perceived to challenge such control are likely to meet with resistance from doctors. The 'professionalised system of control' has drawn heavily on the ideology of public trust in the 'altruistic' vocation of doctors who prioritise the needs of their patients over personal gain (Saks, 1998). This professional 'umbrella' has, in turn, facilitated the presentation of the NHS as being 'needs' rather than 'resource' driven. Any proposal to introduce a more stringent control system under the guise of either managers or politicians, would, therefore, presumably require careful reasoning with the public (as well as to the medical profession), in order to gain the support necessary for successful implementation.

The New NHS can be considered to be a government attempt to introduce acceptable rationales for the structural and ideological changes that were being introduced. Demonstrating such a rationale was important not only in relation to ensuring professional compliance, but also to increase the likelihood of continuing public support. The level of public support for the NHS, as well as professional resistance to any attempts to restrict clinical practice, have limited the effectiveness of previous attempts to impose greater control over the NHS. The aims and objectives that are presented within White Paper were structured to provide a solid rhetorical foundation for the reform measures.

Dingwall and Strong's (1985) analysis of organisational interaction introduces the notion of 'legitimising myths' that operate as general, but loose, constraints on formal

organisational structures. The development of a rhetoric of justification is one way for an organisation to maintain a rational image throughout a period of change; members are provided with the means by which to produce arguments that can be externally sanctioned, and actions that are logically congruent. The 'legitimising myths' introduced in *The New NHS* subtly control members' actions by requiring actions to be accounted for through the rhetorical framework being presented.

In the following sections (5.3.1, 5.3.2 & 5.3.3), I will briefly discuss three of the 'legitimising myths' produced in *The New NHS*. The first of these is that PCGs will be a means through which the quality and efficiency of the NHS may be improved. Secondly, the White Paper proposes that augmented government control over clinical practice will lead to greater equality throughout the NHS. Finally, I will discuss the notion that *The New NHS* facilitated the introduction and augmentation of bureaucratic control mechanisms by making claims that such structures would promote enhanced accountability.

5.3.1 The presentation of reforms as a means of improving the quality and efficiency of care

In the forward to *The New NHS*, the Prime Minister stated that "*Our approach combines efficiency and quality with a belief in fairness and partnership.*" (*The New NHS, 1997; Forward*) He presented the objective of the reform as being to "*ensure that high quality care is spread throughout the service.*" (p. 2).

Through such assurances, policy makers justified engaging in yet another structural reorganisation; this reform was presented as an endeavour towards efficient provision

of higher quality care, with entwined aims of 'quality' care and an 'efficient' service were also presented as entwined. Furthermore, the policy carefully established links between the stated objective of working towards 'higher standards' in health care reform (an objective that most people would find difficult, if not impossible, to refute), and the change initiatives that focused upon the formalisation of regulatory mechanisms, and continued *government* involvement in controlling clinical practice.

"There will have to be big gains in quality and big gains in efficiency across the whole NHS. The two go together. They will bring about marked improvements in services to patients over the next ten years." (The New NHS, 1997: 9)

"Primary Care Groups and Primary Care Trusts will be accountable to Health Authorities for the ways in which they discharge their functions, including financial matters. This will ensure that they work within the Health Improvement Programme and that financial discipline and probity are maintained." (The New NHS, 1997; 39)

The New NHS presents the new PCGs (and the newly formed incentives and sanctions) as being imperative to improving the quality of treatment within the NHS because they will facilitate⁸³ important gains in efficiency and effectiveness.

The establishment of strong rhetorical foundations for proposed changes is not unique to *The New NHS*. The previous Conservative government's 1989 reform initiative,

⁸³ The extent to which the reform's focus on 'efficiency' and increased control was actually driven towards 'controlling cost' (rather than improving quality) was however an important issue to emerge from both my observations and interviews.

Working for Patients, incorporated ideology that was heavily critical of the NHS' existing bureaucratic structure. *Working For Patients* emphasised the effect of the lack of accountability for resource use (Ashburner: 1995), and presented 'free market' principles as the means of addressing public concerns over the rising costs of health care. Policy makers drew upon a business/market rhetoric to justify the focus on reducing spending and transferring financial risk from central government to local health care providers.

Unlike *Working for Patients*, *The New NHS* does not focus on cost cutting measures. Instead, *The New NHS* promised one and a half billion pounds of extra investment (*The New NHS*: 2), and emphasised the need for a more responsible and effective use of the *increasing* resources that would be made available to improve care. At the same time, however, *controlling costs*, remained a policy priority.

"...to drive efficiency through a more rigorous approach to performance and by cutting bureaucracy, so that every pound in the NHS is spent to maximise the care for patients. (The New NHS, p. 11)

The focus on 'improved quality' and 'efficiency', as well as the central role being given to GPs can be understood as part of a 'legitimisation' process for the change initiatives. By outlining a need for greater efficiency within the White Paper, policy makers were able to justify the introduction of clinical governance measures with some hope of avoiding immediate professionally-driven reprisals. The proposed changes were justified by creating an image of the present system as overly 'relaxed' and therefore, wasteful.

“The government will spread best practice and drive clinical and cost-effectiveness in a number of ways: one of which will be by working with the professions to strengthen the existing forms of professional self-regulation.” (The New NHS, 56).

The language of *The New NHS* presents the search for quality and efficiency improvements as relatively unproblematic, rather than acknowledging that these concepts are social constructs that necessarily reflect societal values. Far from being unproblematic, notions of quality are actually inherently complex. *“Performance, standards and quality cannot be assured in any unproblematic way, because they are the core of all conflicts within organisations, and cannot be separated from broader questions of values and interests.”* (Flynn, 1992: 125) Certainly, the data from both observations and interviews in Casterdale would support the notion that the implementation of clinical governance initiatives at the level of local action was far from simple (see section 5.4 and Chapter 6).

5.3.2 The presentation of reforms as a means of achieving greater equality within the NHS

“The Government will put in place new mechanisms to distribute NHS cash more fairly..... There will be a national formula to set fair shares for the new Primary Care Groups, as there is now for Health Authorities. It will be for Health Authorities to determine the pace of change at which individual Primary Care Groups within their area should move towards their fair share.” (The New NHS: 70)

"Some of these developments are already available to some patients, but not everywhere. The government wants to see them available to all as part and parcel of the new NHS." (The New NHS: p. 6)

The eradication of inequality is another central theme within the White Paper. The policy rhetoric builds upon an unspoken assumption that equality is a fairly simple concept, and generally perceived as a reasonable goal for health care reform. *The New NHS* does not, however, include detailed specifications as to what is meant by 'equality' in this instance.

In relation to health and health care, equality can be taken to mean a great number of quite different things: 'equality of outcomes' (all people can expect the same level of health), 'equality of process' (everyone can expect the same treatment or interaction with the system), 'spending equality' (everyone can expect to have the same amount of money allocated to their care), are just three interpretations. The White Paper directly invokes both the idea of equality between individual patients in relation to the care that they receive, and of equality in relation to the distribution of resources across health districts. Such perspectives are not, however, necessarily congruent, but in fact often prove oppositional⁸⁴

The means by which such equality (whatever this is taken to mean) might be achieved, or how widespread standards of excellence would be promoted through the reform initiative, are not classified within the policy document. The White Paper is very vague as to how such 'good practice' and quality control would be instigated,

⁸⁴ The complexities of standardisation are discussed more fully in Chapter 4.

and how the inequalities of care would be abolished. *The New NHS* seems to have been a mechanism whereby policy makers could respond to growing public expectations of government involvement in quality assurance within the health care arena without requiring commitment to particular action trajectories.

One of the strengths of the White Paper's rhetoric is that the notion of 'ending inequalities' is difficult to challenge; most people would concur that a national health service should provide services in an equitable fashion. Providing 'the reduction of inequalities' as an official objective serves as an acceptable rhetoric for measures that seek to standardise costs, processes and outcomes. It may, however, be more difficult to gain widespread support for the necessary steps for achieving such equality.

The White Paper highlights clinical governance as one of the primary means by which greater equality of care would be ensured. Harrison and Ahmad (2000: 142) assert that the 'rhetorical force' of clinical governance measures stems largely from claims that such measures offer the potential to standardise medical practice in the name of fairness. *The New NHS* makes the claim that the NHS' problems are due to a failure to standardise existing pockets of good practice. This message is presumably more palatable than the proposition that unacceptably low standards of care exist throughout the system. The White Paper also makes clear, however, that the operationalisation of clinical governance measures (put in place to ensure greater equality) would be left to local professionals through the newly forming PCG structures. Policy makers were thus able to avoid having to spell out just *how* such standardisation measures will be achieved, and the extent to which these would have an impact upon the stated equality objectives.

5.3.3 The presentation of reforms as a means of promoting enhanced accountability by establishing measurable goals

“There must be improvements in quality and efficiency. Improvements in speed of access to care. Improvements in health, tackling past inequalities. The government requires the new NHS to make progress on all these fronts. A new national performance framework, measuring how local services are progressing against their targets, will shape NHS services to meet the challenge” (The New NHS, 1997; 63)

“To ensure the drive for excellence is installed throughout the NHS, the government will create a new Commission for Health Improvement... ..As a statutory body, at arm’s length from the government, the new Commission will offer an independent guarantee that local systems to monitor, assure and improve clinical quality are in place.” (The New NHS: 59)

The New NHS rhetoric highlighted the extent to which the initiatives would create better measurable targets relating to clinical practice and health outcomes. The reform initiatives were described as being formulated not only in order that *real* progress would be made, but also so that such progress as is made would be able to be determined and accounted for.

Flynn (1992) proposed that defined goals have become an important means of expressing both one’s progress and quality of work, because efficiency and effectiveness are sometimes particularly difficult to demonstrate in relation to health care. With the expectation that one will seek to make progress and work towards defined objectives, so practitioners come to require mechanisms by which they might

demonstrate that they are meeting expectations. Thus, Berg et al (2000) found that professionals do not always strongly resist the introduction of standardised measures such as clinical guidelines. The process of setting common standards and expectations, and augmenting professional regulation may serve the professional agenda of individual clinicians. At the same time, it also serves to facilitate bringing individuals' practices under collective control.

It is possible to introduce and implement more detailed norms and standards within a rhetorical framework of 'accountability'. Reform measures of this kind have, however, typically been avoided in professionally dominated realms because the relevant professionals have tended to perceive any such attempts to impose practice audit as threatening, and thus offered strong resistance. Informal collegial control has therefore generally been proffered as the accepted approach to quality assurance, rather than any formalised or externally moderated system of performance measures.

In line with its historic predecessors, *The New NHS* placed emphasis on the role that professionals would play in delivering cost effective and high quality care (see 5.3.1). The reform rhetoric placed such professionals at the forefront of attempts to monitor adherence to established standards of practice.

The White Paper's prioritisation of demonstrable targets and performance indicators is, however, potentially quite problematic in terms of the demonstrated effectiveness of professional control. The rhetorical power of prioritising measurable targets, outcomes and goals within such a politically sensitive arena may actually serve to promote professional conformance with inappropriate, or ill-conceived norms. If attaining pre-determined targets (whatever these may be) is made the 'be all and end

all’ – regardless of what meeting such objectives might entail, a key element of professional influence may have been eroded.

The prominence given to waiting list targets provides one pertinent example of the possible effect of giving priority to an objective simply because it is ‘measurable’.

The stated, measurable objective in the ‘waiting list initiative’ is to reduce the number of people who are on NHS waiting lists for appointments and treatments. Under the waiting list initiative, the NHS is deemed as either failing or succeeding in its quest to care for the population as judged by the numbers on the waiting lists. The objective of those working for the system must therefore be to get these numbers reduced in whatever way they may. The waiting list statistics do not, however, necessarily reflect for which treatments people are waiting, nor the criteria by which they are put on a list, nor even the length of time that one has been waiting. However, because waiting lists have been identified as an indicator of government success or failure, attention tends to be focused primarily on meeting the targets – rather than attempting to address either why waiting lists are not reducing (or are even growing), or other (perhaps more important) issues.

In this way, a system of measurable targets may become a justifiable means by which economising measures and standardisation are introduced and implemented – often with the concurrence of the professionals involved. There is, however, some indication that the rhetorical power of measurable targets, outcomes and goals may be fairly limited. Commenting on the progress towards the waiting list objective has become a popular topic for both the media and the government’s political opponents. Both the profession and the public’s perception of such measures is becoming quite

cynical, with many measures being seen as unnecessary bureaucracy that detracts from providing actual services (Flynn, 1992).

5.3.4 Summary

The stated objectives and official language of a policy are influential, even if all actors recognise that these are rhetorical devices, rather than a reflection of reality (Klein, 1995). The introduction of new ideas is likely to change the context in which local action is situated. Action will be shaped through the recognition that the ideological ground has shifted with the reform, even if the local reality seems to have stayed the same. Actors may then adapt justifications provided for their acts in order to attempt to fit with the changing ideological context. Over time, the ideological rhetoric will become the contextual reality, although this is likely to be a slow process.

5.4 What does strengthening ‘medical control’ actually involve at the local level?

The White Paper presented numerous fairly abstract notions as to how the reform of the NHS would shape the provision of services at the local level, particularly focusing on how the newly forming PCG structures would assure better standards of care. It did not, however, provide much detailed information about how the ideas presented should be translated into workable practice. The means by which greater efficiency, accountability and control over clinical practice would actually be achieved through the reform measures were rather left to be formulated, discussed and negotiated locally. To this extent, the actual White Paper left considerable room for local negotiations around workable applications for the proposed changes.

During my fieldwork, I was able to observe a local negotiation process over the implementation of the reform initiatives. These negotiations included various local actors, (particularly local GPs and local managers) who were able to call upon different arguments in order to defend their own position within the change process. In the following sections, I will present data from my observations and interviews that illustrate the extent to which the reform initiatives were incorporated into pre-existing local structures. I will use these data primarily to consider the instances in which GPs were able to align with the initiatives in order to serve their own professional agenda.

5.4.1 Strengthening and formalising professional self-regulation as central to the official agenda of *The New NHS*

“The Government will continue to look to individual health professionals to be responsible for the quality of their own clinical practice. Professional self-regulation must remain an essential element in the delivery of quality patient services. It is crucial that the professional standards developed nationally continue to be responsive to changing service needs and to legitimate public expectations. The Government will continue to work with the professions, the regulatory bodies, the NHS and patient representative groups to strengthen the existing systems of professional self-regulation by ensuring that they are open, responsive and publicly accountable.”
(*The New NHS*, p. 59)

“Primary Care Groups will be expected to help primary care professionals to enhance the quality of their care.” (*The New NHS*, p. 41)

The New NHS emphasised the importance of a strong system of professional self-regulation to delivering higher quality clinical practice⁸⁵. The White Paper defined PCGs as principal structures for ensuring that standardised quality initiatives would be delivered.

“Primary Care Groups will develop primary care by joint working across practices; sharing skills; providing a forum for professional development, audit and peer review; assuring quality and developing the new approach to clinical governance; and influencing the deployment of resources for general practice locally.” (The New NHS, p. 34)

The White Paper also stressed that PCGs would be expected to rely largely on professional audit to deliver both nationally and locally determined performance standards and outcome measures – at least temporarily⁸⁶. In practice, however, such reliance on collegial control was somewhat problematic. The existing formalised authority structures for GPs were relatively weak. In many areas professional control essentially existed as an ideal, rather than a reality. Historically, relationships between certain practices had been relatively fraught, and a culture of mistrust rather than collaboration had developed. Experienced local actors (such as the Chief

⁸⁵ Professional self-regulation was not the only means by which standards of professional practice would be assured; new national structures were also being introduced in the form of the National Institute of Clinical Excellence (NICE) and the Health Improvement Programme (HIMP). A discussion of the impact of these new structures on local practice is, however, largely outside the scope of this study.

⁸⁶ The ‘staged’ structure of PCGs introduced a level of uncertainty over the continued leadership role for professionals in the long term. Transition to Primary Care Trust status (Level 3) would necessitate considerably enhanced roles for ‘lay’ members of the board.

Executive of the Local Medical Committee) displayed considerable scepticism about the extent to which such inter-practice cooperation could actually be achieved.

Chief Executive of the Local Medical Committee - "...a job trying to referee the disputes between practices. They don't get on. They won't talk to one another. And you are saying, "You've got to work together. You've all got to be part of the same group. But you are going to be deciding how to divide up the money between practices.' Which is a recipe for disaster because these guys won't talk to one another. We've tried everything. You also expect them to clinically govern, performance manage all the diverse practices and all of the rest of it. What a nightmare!"

(Interview data)

although local history clearly indicated problems with a professionally mediated system of clinical control, this model was supported by the Health Authority. The Chief Executive of the LMC provided one possible explanation for the Health Authority's support for such a transfer of control to a professional structure, in that the transfer might allow the Health Authority to shift responsibility for the contentious issue of clinical governance to the professionals themselves.

Chief Executive of LMC – "Local implementation officer outlines one of the reasons why managers may be in support of emphasising the role of collegial regulation.

Under such a system, the Health Authority would be relieved of some of the headaches of being responsible for monitoring spending..... It will be peer group pressure, not the Health Authority saying, 'Look, there is no more money- stop what you are doing.' They will be looking at each other, which is quite a different kettle of fish from a fundholder being scrutinized at year end by the Health Authority on

performance against the business plan. It is only them sitting there being scrutinized."

(Interview data)

The White Paper also clearly laid out high expectations with regards to the application of professional control on identified problem areas within the NHS. There is, however, considerable historical evidence (see Chapter 2) to suggest that professional adherence to externally formulated objectives is potentially problematic. Indeed, my data did not always indicate that policy makers' expectations were necessarily translated directly into working practice.

The reform's expectation that professionals would monitor one another's practice was quite clear, but this did not necessarily match local circumstances, traditions and structures. One Health Authority public health consultant who was interviewed expressed reservations about GPs' willingness to restrict their colleagues' practice. He provided his previous experience in trying to limit GPs' Extra Contractual Referrals (ECRs)⁸⁷ as support for his prediction GPs would not willingly engage in the regulation of one another.

Public Health Consultant – "I have not been able to get the GPs on the commissioning board to say, "No" to anything. When I have said, "Please ring up Dr. X and tell them that as a commissioning board you do not think that this is an appropriate treatment for Casterdale to be purchasing." They will not do it. They

⁸⁷ ECR is the practice of referring patients for care that falls outside of the boundaries of existing contracts between a health authority and secondary/tertiary trusts (e.g. to a specialist London hospital).

say, " No, we cannot possibly say anything to Dr. X. Apart from anything else, we see him at the LMC (Local Medical Committee), or my partner is a friend of theirs." They won't do it and this is where we are really going to come unstuck with PCGs."

(Interview data)

Leaving aside the issue of whether GPs might be willing to engage in more formalised collegial control, it was not clear how effective attempts to impose such controls would necessarily be. Both the meeting and interview data demonstrated displays of significant uncertainty among local PCG GP board members (and potential members) as to how individual GPs might be 'brought into line' in terms of their clinical practice and referrals to secondary services. The 'carrot and stick' dichotomy was frequently mentioned by PCG GPs, seemingly as a counterbalance to their expressed reluctance to directly intervene in others' practice.

In the meetings that I observed, GPs did not discuss any details of enforcing augmented professional regulation, but rather produced accounts that portrayed professional governance as essentially facilitating collegial support for fellow professionals in addressing their own problems. These accounts of professional self-regulation emphasised individualistic, rather than collective notion of 'self' (with regards to 'self'-governance). In this way, GPs were able to mould abstract ideas of professional governance (as outlined in the White Paper documentation) into quite positive portraits of collegial control, which offered little challenge to either professional culture or cohesion.

Since local contracts incorporate 'bulk' purchases they are usually cheaper (at least at face value). Thus, following *Working for Patients*, efforts were expended to minimize the number of ECRs.

5.4.1.1 GPs' negotiation of self-regulation: the presentation of collegial control as an empowering process

Many of the initiatives in *The New NHS* were based upon the foundations of a strengthened system of professional supervision. At the level of local implementation, however, GPs tended to decry a potentially disagreeable, *active* system of professionally dominated regulation, in favour of a depiction of collegial governance as a 'genteel' and 'dignified' process. The following account provided by one of the PCG Chairs suggests how the reform measures might be incorporated into the existing culture of respect for professional autonomy. His perspective of collegial direction was not one in which control was forcibly taken from individual practitioners, but rather one in which a system of support for individual initiatives was carefully instigated.

GP – "What we want to do is a mapping exercise so that we can then feed stuff back in an aggregated form to practices in an individual form until they are ready to share information. To show where they are in terms of their performance in relation to the average for the PCG, for Casterdale. So, for example, if they have only diagnosed X cases of ischaemic heart disease in their population and you would expect Y and the average for Casterdale is Z and they are way far away from either of those two, then hopefully they will think, 'There is something wrong in our practice. We are not picking up these people. What can we do about it?' There will be a sharing of good practice in the PCGs, so that we can say, 'Well, the practice down the road has a similar population to yours. This is what they do'.

The first thing is to actually enable practices to see what they do already – not to point fingers of blame at them, and not to go at them with sticks, but through the process of peer pressure, and self education to try to change the way that professionals are working.

Now, if somebody comes along with a rule book and a big stick and says, 'As from now, you will do this, this, and this or else.' You are going to get those GPs who are in their 50s who are already pretty pissed off with the whole affair saying, 'I can't handle this. I am getting out.' So you will get more of them going out. I think that there will be more and more problems with recruitment if it is seen to be externally controlled, whereas if we can do it from within PCGs, it is professionally led, there is more multi-professional working to see how things can work better, I think that we will keep people on board."

(Interview data)

The system of professional self-regulation as laid out by the PCG GPs involved providing colleagues with information through which they would then be able to improve their own practice. This image of collegial control was compatible with notions of professional responsibility, and undermined the need for a more active and invasive hierarchical system of professional control.

GPs generally adopted a model of collegial control in which the board members took on the role of 'advisor' or 'mentor' (rather than that of 'enforcer') in relation to clinical governance. The following interview data provide an example of this model of collegial control. This GP's account represents a 'casual' system of professional support (rather than formal supervision). Professional regulation would consist

primarily of colleagues showing an interest in others' progress towards objectives that reflect collectively held values, but are driven by the individual practitioner. Quality control would remain the individual's responsibility and domain, with colleagues serving as prompts for where attention might be best turned. The model of collegial control presented in this account gave emphasis to the individuals' progress, rather than focusing on any remaining problems or shortfalls. The account also hinted at a potential conflict over repudiating many practitioners because of the NHS' current doctor shortage.

A local GP active in the RCGP - "I think that most practices when they have a friend and supporter and mentor and the director of clinical governance, hopefully will be or they will be able to appoint somebody to do the role, then hopefully what they will have is someone who turns up every month or so saying, 'And how are you getting on with changing your staffing arrangements? How are you getting on with upgrading your premises? How are you getting on with protocol for diabetic care? How are you getting on with improving the quality of care and the quality of recording on your computer system? How are you getting on with increasing the number of appointments so that the patients have more availability?' All of those sorts of issues. And if they are moving in that direction then I think that we ought to be applauding them and saying, 'Ok. So they are not particularly good, but at least they are better than they were six months ago, and at least we have got every reason to believe that they are going to be better in six months. Therefore, we have got to help them along and integrate them back into the medical community. And then of course there will be a small number that we will have to repudiate. And repudiation should be first to the Health Authority and then through them to the GMC and there will be a small number- it is inevitable and we have got to control the number.'"

(Interview data)

The next extract is from an interview with another GP PCG Chair. It serves as further demonstration of the extent to which 'modest' applications of professional regulation over practice were being proffered by the GPs involved in implementing the White Paper. His account highlights a perceived vacuum around existing collegial standard-setting, and offers fairly limited plans for expanding collegial regulation through the new PCGs.

PCG Chair – "Certainly it is unusual to say 'Well, we have perceived a need for this. Are you going to join us?' I think that that can only be for the good and that is the preferred mechanism for improving standards - getting people involved in different work, so that people whose standards are lower will ... Just a general feeling of collaboration rather than competition."

(Interview data)

This PCG Chair did not present a model of collegial regulation as a system of formalised monitoring of practice that is done by a few, and imposed on many. Rather, he portrayed collegial regulation as a collective formulation and control of practices and standards of care.

Accounts of collegial control provided by GPs who held positions on PCG boards continued to emphasise the extent to which this process would be 'information based', 'persuasive', and 'empowering'. Such accounts may have been employed to gain the necessary compliance of professional colleagues' with the new structures. Data from an observation at an open stakeholder meeting within one of the PCGs demonstrates

the employment of such ‘positive’ accounts of collegial control by board members to allay concerns over how peer evaluation would be conducted, and its potential consequences. The following account of supervision provided by the Chair focused on facilitative and informative processes, rather than on regulations or sanctions.

Representative from the voluntary sector – “Where does the evaluation come from?

This is a touchy subject.”

GP PCG Chair – “We need to show people where their practice stands in relation to others. People don’t like to see themselves out of line.”

Representative from the Ambulance Service – “There needs to be the appropriate atmosphere – to avoid the feeling of blame.”

Chair – “People that are out of line may not have access to resources. The PCG may be able to address this.”

(Observational data)

One of the Health Authority managers who was interviewed summed up the approach being taken in relation to regulations as follows, *“They have got to be seen as being very friendly and open and listening at the moment to get the support of the GPs in the area. I think that they have to win that first.”* Both the GPs and local managers gave accounts of a very careful, ‘softly, softly’ approach being taken to introducing increased collegial regulations. These accounts highlighted the extent to which the new controls would be informal and supportive. The issue of ‘enforcement’

of any new structures was clearly relevant, although the term ‘enforcement’ seemed to be avoided.

The means by which PCG boards would gain the support and ‘obedience’ of their members were prominent over the fieldwork period. The data suggest that from early on in the process of establishing collaborative structures such as the TCG and the PCGs, the structures of clinical governance being implemented were quite formal and hierarchical in nature. Even before the PCGs were instigated, and strengthening collegial control was made an official priority, members of the TCG Forum expressed a willingness to restrict colleagues’ clinical freedom in order to access additional resources; the ‘success’ of The Total Commissioning Group (Project)⁸⁸ depended on GPs making collective commitments that prescribing behaviour would be curbed in return for potential collective financial incentives.

During the life of the TCG (just less than a year), the decision-making powers of this elected professional body were strongly asserted, as was their right to enforce decisions on members’ practice. Much of this work, however, seemed to take the form of establishing a rhetoric of control, rather than actually attempting to enforce the power of Forum members over others’ clinical practice. My observational field notes from the first TCG open meeting include a description of the formality of the structure, and the ways in which this meeting seemed to be used to establish the authority of the GPs who had been elected to the Project Board. The format and tone

⁸⁸ Over the course of my fieldwork, the Total Commissioning Pilot became the Total Commissioning Group. This transition was not, however, a particularly marked event because by this time everyone was anticipating the establishment of the new PCG structures.

of this first TCG meeting was very formal, with the TCG Chair and Project Board members asserting their mandate.

The meeting itself took place in a lecture theatre that had a formal feel to it. There was a chair who presented the main body of the meeting's contents and the 'project board' also sat at the front of the lecture theatre, facing the audience and fielded some of the questions in the later part of the meeting... .. The structure of the meeting was strictly adhered to by the chair.

(Observational field notes)

The creation of a legitimate professional hierarchy seemed to be an important task for both the TCG Forum, and later for the PCG Boards. The Health Authority manager with responsibility for commissioning commented that,

Health Authority manager - "They have got to create authority at the same time because otherwise there will be a mass rebellion, because they are GPs from a particular patch who are going to make decisions about that patch, GPs and nurses, and then you have potentially got the constituency, potentially to support you and empower you, or to challenge you. To say, 'What right have you got to make decisions about my practice income? Or my practice staff, or my clinical practice?' So, they have got to work a lot on the PR [public relations]. And that is an early task."

(Interview data)

At the same time, the data indicate that the board members (of both the TCG and the PCGs) worked to ensure that they were seen to be introducing initiatives that were grounded in the existing culture, were potentially advantageous to the profession and

had ground level support, rather than imposing any draconian control measures. For example, when addressing potential GP members, the TCG Chair presented the Project's main initiative (which would involve strengthened systems of collegial control over prescribing practice) as a matter of professional empowerment rather than regulation. In outlining the need for increased data from practices regarding referral practices, he made assurances that practice data would not be used to further 'control' GPs. Rather, his account of collegial control illustrated the importance of good information to continued professional development.

The need for a more accurate information system was also presented as potentially beneficial, and as something to be embraced by the GPs'. This depiction drew upon a professional culture that prioritises individual and autonomous professional responsibility. He stated that, *"The data will be used to inform you, not to police you. It may make you think upon your practice."*

The active role of individual practitioners in monitoring their own practice was also given primacy in this account. The Project would serve as a facilitating resource, rather than a regulatory body.

(The Chair showed examples of the type of practice data that could be collected to the GPs on an Overhead Transparency) "This is the sort of information that we can send out to practices so that you on the ground can see what is happening in your practice."

During this meeting, the Chair did not make any attempt to engage the GP audience in the process of formulating what data might be gathered, and how it should be applied. Furthermore, over the coming months, only those GPs who had been elected to the

TCG Forum and Project Board were given the opportunity to formulate appropriate prescribing levels, and to shape standards of clinical practice. This body would, in turn, relay the information that they deemed necessary back to the GP members, in order that these individuals could then modify their own practice, so as to be in line with such pre-determined expectations.

Subsequent reports relating to the TCG prescribing budget suggest that matching collegial control with financial incentives had significant effects on the extent to which GPs were willing to engage in regulating one another's clinical behaviour. In establishing the TCG, the Government had declared a willingness to allow an 'overspend' of the Casterdale prescribing budget by up to £860,000 on top of the £44 million that had already been allocated. The TCG was established on the basis of an agreement that if the GPs stayed within this budget (including the overspend), they would receive a substantial financial incentive that could be applied to clinical realms beyond prescribing (usually any under spends were either 'clawed back', or at best, could only be spent in allocated areas).

In the initial open meeting, the TCG Chair described the target of staying within the 'allowed overspend' as being, *"Difficult, but not impossible, if we work together."* In fact, eighteen months later, the TCG was reported to have stayed within its original prescribing budget, without needing to use any of the overspend. The project was summarised in a report to the Health Authority Board given by a Public Health Consultant in the following way.

Public Health Consultant - "The TCG GPs have worked very hard to remind their colleagues that they have limited funds. This kind of corporate target setting for the TCG has had an influence."

(Observational data)

Collegial control, formal or informal, had been extremely effective in this instance. I conducted interviews with Health Authority managers who were concerned that GPs would either be unwilling or incapable of controlling colleagues' practice. They raised questions as to whether the established professional culture as well as personal ties would prevent GPs from 'interfering' in each others' work. There were only limited examples of engagement in collegial control during the shadow period, but the examples that were presented within meetings certainly appeared to refute the assumption that GPs *could not* effectively regulate each others' practice.

5.4.1.2 GPs' negotiation of self-regulation: a limited engagement with the idea of clinical guidelines and performance measures

"... the government will set a framework of national standards and will monitor performance to ensure consistency and fairness." (The New NHS, p. 9)

"In the new NHS, there will be new mechanisms to share best practice so that it becomes available to patients wherever they live. A new national performance framework for ensuring high performance and quality will, over time, tackle variable standards of service." (The New NHS, p. 14)

The incorporation of stronger clinical guidelines and standardised performance measures into daily practice was one of the key initiatives laid out within *The New NHS*. Such measures were presented as being central to the government's attempts to gain greater control within the NHS. The introduction of measures to both direct and

assess clinical practice can be interpreted as a potentially radical step towards non-professional involvement in (and perhaps control over) how clinical care is conducted. To such an extent, such initiatives would be a challenge to clinical autonomy on a daily level, because they would be an “important vehicle for circumscribing practice.” (Harrison and Ahmad, 2000: 130).

Previous formalisations of control measures tended to be received by GPs as posing serious threats to their existing professional authority, and therefore faced strong opposition (as discussed in Chapter 2). There is no reason to believe that GPs would necessarily receive this reform any differently. The following extract is taken from an interview with a politically-active local GP. It illustrates the extent to which (shortly after the release of the White Paper) the reforms of *The New NHS* were indeed being formulated as a government ‘power play’ against general practice.

“So you could say, and I think that you probably would, that actually the advent of PCGs by the government is an attempt to reclaim power over general practice.”

(Interview with a local GP active in the Royal College of General Practitioners)

In contrast to the expected professional resistance to control measures, however, the Casterdale data revealed considerable evidence of both local managers *and* GPs actively engaging with the principle of collective clinical guidelines. Local actors worked to establish clinical governance structures, to identify appropriate performance measures, and eventually to develop assessments of health outcomes. One of the GPs who was interviewed presented an account of GPs who were (at least officially) beginning to subscribe to the idea of involvement in more active clinical governance. This account also revealed, however, the extent to which such GPs were working to claim greater professional control over this process.

GP – “So, performance issues and quality issues of general practice – recognising that at the end of the day it is a PCG responsibility. But, in the initial stages, somebody had to set the ball rolling.”

KC – “How far are you with that?”

GP – “That is at the stage – there are now representatives from each PCG who will be sitting together as a body to oversee this. It is just at the stage of getting going. It had its first meeting. They are all working. There are things that we have been involved in, meetings through the autumn to look at possible members for that – the structures, that then had to have the agreement of the PCGs”.

KC – “Have they been fairly supportive of this idea?”

GP – “ Yeah, that seems to have been fairly accepted. There are issues around the financial side of it – who pays for it? I think that they realise that this is something that we have got to do and it is probably sensible to do it jointly.”

(Interview data)

Professional submission (at least on some superficial level) to the idea of clinical governance as operationalised through guidelines, targets and measures was evident in the establishment of (and engagement with) various PCG structures. By the end of the fieldwork period, ‘Clinical Governance Leads’⁸⁹ had been established within all of the PCGs, despite GPs’ initial expression of doubts as to whether anyone would be

⁸⁹ Individuals who would take responsibility for clinical governance measures.

willing to take on this role. In addition, support structures were being instituted for the 'Clinical Governance leads', and work was ongoing to organise collaborative meetings between the PCGs to facilitate the formulation of compatible programmes of performance monitoring and collegial audit.

GPs' relatively positive reaction to the proposal of additional 'interference' in clinical practice should be considered alongside the powerful rhetoric surrounding these measures within the White Paper. The policy framed performance measures, guidelines and targets as essential tools for developing a system based upon *accountable* practice. The GPs' general acquiescence to the introduction of strengthened clinical governance measures seems likely to be (at least partially) a reflection of a felt inability to openly reject measures that were so clearly couched within the White Paper's rhetoric of working to provide improved quality care for all patients.

GPs may have assessed that it would be difficult to maintain an image of sound professional integrity if they were seen to reject the notion of accountability – particularly when this was so closely tied to measures outlined as improving the quality and equality of care. Embracing the initiatives on the basis of altruistic concern for patient care was perhaps more shrewd than any possible rejection on the basis of professional umbrage. The position put forth in one of the GP interviews gives an indication of how these clinical governance initiatives could be incorporated into an strengthened claim to professionals based on 'altruistic' accountability (Saks, 1998).

GP - "If you translate this across the board of all the professionals, that means that there is a sharing of responsibility, a sharing of quality control, a sharing of consideration, and there is only one winner here and that is the patient."

(Interview data)

In turn, a demonstration of compliance with measures defined as being central to the formulation of an accountable, quality service may have been concession enough to provide GPs with a certain amount of valuable 'space' over the actual implementation of performance regulation. Such space could then be used to ensure that the measures did not significantly affect daily practice.

The incorporation of such clinical governance measures in Casterdale does not, however, reflect mere professional submission. The data also suggest that straightforward professional compliance with clinical governance measures may have been limited to structural (and thus perhaps superficial) changes. Over the fieldwork period, (and even once the clinical governance structures were in place) there was debate as to exactly how the new measures would be incorporated. The question of who had legitimate authority to create and enforce such guidelines was a frequent and impassioned topic at meetings.

The following comments were made by one GP at an early PCG meeting in which several GPs had expressed concern over processing newly emerging clinical guidelines. The GP took the opportunity to raise concerns over the ability of specialists to produce guidelines without consulting the PCG, and to express concern that in the future clinical guidelines may be employed to ration care.

GP1 – “What we have to do is to stop little groups of consultants from producing guidelines that favour their pet projects. We need to get Health Authority backing on key issues. What our job as a PCG is to distribute the guidelines and to keep up to date with them – to modify them regularly. Once we are a trust we will have to ration medical services. Then we may have to look at guidelines again as they may be used as a way to ration care.”

Discussion ensues about the use of guidelines for rationing purposes.

Discussion about how the guidelines come through the commissioning board and the prescribing group.

GP1 – “Its an issue of whether you trust these people to bring to our attention any controversial issues.”

GP2 – “These are by design a product of consensus, and they are guidelines – not orders.”

GP1 – “ It is worth noting that these are produced at the programme level of the TCG [actually the Collaborative Commissioning Mechanism by this point], and may not go to the board level.”

(Observational data)

Although Casterdale GPs seemed on some level to have generally accepted a role for more formalised clinical control measures, the operationalisation of clinical governance was also significantly moulded by a continued prioritisation of *locally* controlled measures. The discussions of clinical governance in Casterdale tended to assign primacy to guidelines that were locally formulated, and such ‘home-grown’ initiatives were supported by both GPs and managers.

The following data is taken from one of the final TCG meetings before the transition to the Collaborative Commissioning Mechanism. In this meeting, the GPs were discussing the progress made by one of the locally formulated, collaborative governance structures. This group had produced one set of guidelines (on cancer) that GP1 was encouraging his colleagues to incorporate into their practice. He also requested that GPs provide feedback to the group on the guidelines. The GPs indicated support for this set of guidelines and for the group that produced them. Their discussion anticipated further GP participation with this new structure, as well as the collective incorporation of its products.

GP1- "The first meeting of the cross-town cardiology group has taken place. It was one of the most fascinating two hours of commissioning work. It was an illustration of the need to co-ordinate what is happening across town. This is absolutely crucial."

GP2 – (showed the gastro guidelines). "We had our first meeting last week. The specialists asked me to chair it. We need some sort of form for the new forum to take."

(This led to a discussion of who should be on the new forum, how it would work, and who would fund it? So far such work has been done on good will. How will the new PCGs contribute?)

GP2- "I think that this forum and others are very valuable."

GP3- "You should all have received the cancer reference manuals. We would appreciate feedback, especially as there wasn't much GP involvement in the production stages. The manuals should be updated regularly."

GP2 discussed the work that had been done on diabetes. "The diabetes work is excellent. This sort of thing will be key to the evaluation of PCGs."

(Observational data)

Similar collaborative forums on epilepsy and prescribing were established during the fieldwork period, and also received strong support. Such local initiatives tended to be described in terms of 'ownership' and pertinent focus. In both meetings and interviews, locally determined control measures were presented as being more realistic, more in-tune with patient need, and more compatible with existing practice. In contrast, centrally formulated guidelines and targets tended to be dismissed as overbearing, unrealistic and disparate. The GPs and local managers reflected on the likelihood of difficulties in successfully implementing such measures, and the extent to which these might provide workable solutions. Managers and GPs asserted their support for the general idea of guidelines, while at the same time portraying central guidelines as being disruptive to effective, local progress.

Health Authority Non-executive – "It seems to me as if we are advancing on a 500 mile front. There are too many targets. I couldn't hold fifteen targets in my head at once. We need to prioritise some targets, meet these, and then move on."

Health Authority Non-executive – “We are all swamped by initiatives from central government. The only thing that is really important are outcomes.”

(Observational data)

Both managers and GPs tended to frame the issue of locally and centrally formulated guidelines in relation to the importance of establishing feasible, achievable targets during the formative period for PCGs. Their accounts emphasised that the establishment of a perception of progress was key to the work of confidence building and bonding within these new structures, and such progress would be more easily demonstrated in relation to locally structured initiatives.

(Interview with an Implementation Manager)

“The two targets that we have set for the Health Improvement next year – one is a very medical sort of improvement that is related to diabetics and cholesterol screening, which was something that the board felt engaged all of the local GPs.”

Concordance between GPs and Health Authority managers over this issue may have resulted from the extent to which they both appreciated a greater ability to control ‘locally formulated, clinical governance’ structures. The application of a ‘local’ rhetoric by GPs and managers also fit very well with many of the ideas being proposed within the White Paper; whereby care was most appropriately managed at the local level. It did not, however, fit particularly well with the White Paper’s concurrent rhetoric of the necessity for a strong underlying structure of centralised control.

The data indicate that both local managers and GPs tended to concede that clinical standards (in the form of guidelines, targets and outcome measures) had a recognised

role in the provision of health care. The data also suggest, however, that these actors were actively engaging in work to limit the extent to which such measures would constrain local autonomy.

5.4.1.3 GPs' negotiation of self-regulation: avoiding engagement with the issue of sanctions

The outline of collegial control as presented within the White Paper essentially maintained clinical regulation within the bounds of professionalism. The collegial approach to clinical control was potentially quite beneficial for GPs, but it did entail engaging with ideas about how such control might be managed. The Casterdale data, however, revealed that by and large, the GPs avoided any detailed discussion of the repercussions for professionals who did not adhere to collectively defined standards or practices.

The data from the initial TCG meeting indicated that from the earliest days of more formalised GP involvement in resource allocation, some GPs had begun to consider the possibility of imposing sanctions onto colleagues if collective budgets were exceeded. At this meeting, the Group Board (represented by the Chair) outlined the extent to which adherence to a collectively determined budget was central to the success of the initiative. At the same time, he drew a comparison with fundholding, seemingly in an attempt to allay fears over the likely impact of such budgetary measures. Even when asked a direct question, the Chair avoided engaging in a discussion of the possibility of having to impose sanctions on GPs who did not adhere to the agreed prescribing guidelines.

GP – “What happens, apart from the loss of incentives, if a GP over prescribes? Will we come to a point where GPs are told to stop prescribing because their budget is gone?”

Chair - “Going over budget would have an impact for hospital services – just as happens with fundholders at the moment. The Health Authority needs to balance their books. But, I don’t believe that we would ever say, ‘Stop prescribing.’”

(Observational data)

The Chair’s comments reinforced the idea that budgets would be closely monitored, while also offering reassurance that such work would be done in moderation, and would not be unduly oppressive.

When the issue of possible sanctions was brought up again during this meeting, the Chair once more avoided commenting on this, and instead referred the decision for future consideration by the collective. At this point, the Chair also dismissed the idea that GPs might refuse to provide practice information. He rather reasserted that submission to structures of collegial moderation was essential, and delegated responsibility over the contentious issue of non-compliance to the collective membership to deal with at a later point.

GP – “Are you going to make us give the information? Can we say no?”

Chair – “We need to give an incentive to everyone. Quality is an issue. We don’t want to police but if people don’t want to co-operate then we will have to talk about penalties.”

GP – “What will the penalties be?”

Chair – “It is for us to decide as a community.”

(Observational data)

By calling on collective discretion in relation to penalties, the Chair was able to distract the GPs away from the potentially divisive issue of the TCG Forum members imposing practice restrictions and sanctions on TCG GPs. The Chair did not engage the GPs in making a decision at the present time, but instead invoked an abstract future “us”, who would be charged with making and enforcing any necessary decisions.

GPs’ ‘tame’ accounts of collegial control were not, however, only produced in meetings for the sake of convincing colleagues to assent to the new regulatory structures. GPs who were interviewed also presented very similar perspectives on how such control initiatives would be implemented.

PCG Chair - “The first thing to do is to actually enable practices to see what they are doing already – not to point the finger of blame at them. And, not to go at them with sticks, but through processes of peer pressure, and self-education to try to change the way that the professionals are working.”

(Interview data)

In another interview, one of the other PCG chairs expressed a similar perspective.

KC – “What do you do if and when the crunch comes about people not wanting to give resources up?”

Chair – “I don’t know. Apart from – my answers would be soft answers. You would go and talk and persuade and stroke, stroke. When it comes to somebody saying, ‘Well, tough.’ Irrespective of what you say, I guess that we have it within our powers to say, ‘Your staff budget next year is going to be £10,000 less than it is this year.’ I think that we have it within our powers to do that, that is why I think that at that stage it is better that everybody knows what is going on. It is all open and above board, so even if one practice is trying to fight what everybody else sees it is a fair thing to do.”

(Interview data)

GPs’ avoidance of detailed discussion regarding ‘sanctions’ for inappropriate or low quality practice seemed to be a striking incongruity with both the reform’s stated objectives, and public expectations around clinical control. GPs’ accounts of peer control also contrasted quite sharply with the evolving local practice. Their representation of collegial control as a facilitative, rather than a prohibitive mechanism, involved a sophisticated manipulation of the reform rhetoric. This served to allow enhanced collegial regulation to be accounted for in relation to strengthening professional privilege, rather than serving as a challenge to it.

Throughout my fieldwork, the question of possible consequences for GPs who might choose not to subjugate themselves to collegial control remained of central concern. Casterdale GPs seemed to find it problematic to reconcile enhanced systems of professional self-regulation with existing concepts of collegiality. A particular

difficulty emerged in relation to the traditional presentation of professionalism as homogeneous, rather than hierarchical. The status of each individual professional has been such that they have not expected to be subject to active peer supervision. The introduction of a more formalised system of collegial regulation served to challenge the status quo in relation to this aspect of GPs' professional experience.

In practice, however, the GPs involved with the TCG and PCGs seemed both capable and willing to engage in enhanced professional control – particularly if they perceived potential professional incentives for doing so. The extent to which the formalisation of collegial control would prove to be problematic beyond a rhetorical dimension (i.e. in daily clinical practice) was not, however, clearly demonstrated in this research.

5.4.1.4 Summary

“PCGs will have the benefit of strong support from their Health Authority and the freedom to use NHS resources wisely, including savings. With these new opportunities will go the need to account for their actions. They will be subject to clear accountability arrangements and performance standards.” (The New NHS, p. 34)

The government's reform objectives, as elucidated through *The New NHS*, clearly rested on greatly strengthening the existing structures of clinical control. These objectives were, however, dependent on local enactment, and were therefore subject to local adaptation and interpretation. My data suggest that the idea of clinical governance was on the whole (at least on some superficial level) accepted by both GPs and managers. Wherever possible, however, both groups acted to promote local initiatives over those that had been formulated centrally. In addition, GPs in positions

of emerging power largely avoided engaging with the notion of imposing collegial sanctions, but instead presented moderate accounts of professional control based upon a mixture of self-discipline and gentle persuasion.

The apparent breakdown of effective professional regulation was one impetus for this set of reforms. The White Paper's rhetoric emphasised how new structures would replace the existing, ineffective systems of control. The data reflect the translation of the reform rhetoric into workable structures, although the extent to which this new system will actually differ from pre-existing systems of collegial self-control remains somewhat uncertain.

5.4.2 Other Control Initiatives

5.4.2.1 Making Professional Financial Accountability *Collective*

In Chapter 4, I outlined the extent to which *The New NHS*' reform initiatives devolved control to local professionals. Although in practice this transfer of authority is nowhere near as simple as suggested in the White Paper (as discussed in Chapter 4), increased financial accountability on the part of local GPs was clearly a core component of the reform initiative. The devolution of financial accountability sat closely alongside the prioritisation of collegial control measures, and the reform initiatives intertwined financial control with more active systems of collegial regulation. *The New NHS* provided GPs with a more active official role in determining the allocation of resources in return for GPs' agreement to assume increased responsibility for ensuring that such resources were effectively allocated.

GPs' lack of a strong and cohesive collective structure was, however, a potential drawback when faced with incorporating such devolved responsibility.

Prioritising collaborative and locally controlled financial accountability had some precedent in Casterdale in the form of the TCG. The Total Commissioning Group was centred around the devolution of the prescribing budget to a collaboration of local GPs. An agreement was made between the Health Authority and the GPs elected to the TCG Forum to hold the incentives for this initiative at a collective (project) level⁹⁰, seemingly to minimise individual practices' spending on prescriptions by creating uncertainty about overall spending levels⁹¹.

At the initial TCG meeting, however, GPs considering joining the project expressed considerable concern and dissatisfaction over the decision to amalgamate prescribing budgets on a district wide basis. The GPs resented that the eventual calculation of 'budget adherence' at the district level meant that one practitioner's 'rogue' prescribing could prevent the entire district from receiving the 'prize' of additional funds. One GP in the audience commented that the decision was, "*a silly one*", and the topic spurred heated debate.

The GPs in this (and subsequent PCG meetings) expressed confidence about controlling their own practice and spending levels, but not that of their local colleagues. Many said that they felt that the incentive to keep prescribing costs low would be more effective if it was practice (rather than project) based. The Chair,

⁹⁰ This decision was made before I began my data collection, and I do not know on what basis it was made.

⁹¹ The resolution of the issue is dealt with as a 'negative case' within the 'Consensus' chapter. The project board essentially ignored relatively widespread disapproval of the decision.

however, countered that 'high spending' practices had already been identified and would be targeted, but that the premise of this project was that there were additional savings to be gained by encouraging 'middle range' practices to make minor modifications.

The imposition of collective financial accountability through the TCG had somewhat surprising results. It seemed to lead some of the GPs to quickly abandon the 'gentle' approach to collegial control that they had espoused when such measures had been discussed hypothetically. The data suggest that the GPs were not comfortable trusting their colleagues to adhere to spending guidelines when their own access to resources was dependent on such behaviour.

The shift from a model of clinical governance based upon 'gentle persuasion' to one built upon fairly active supervision became apparent at the initial TCG open meeting. This meeting took place shortly after the Forum had received the first set of practice prescribing data from the Health Authority. These data revealed that there were considerable differences between GPs' practices and spending levels. At the open meeting, these differences were drawn upon by the Forum members to illustrate that certain GPs needed to modify their practice.

Some of GPs in the meeting seemly fairly disconcerted by the revelation that colleagues' practices might threaten available resources. There were calls from the floor for active measures to be taken to ensure that 'rogue' practices were being dealt with. In the following data extract, GP1 expresses concern about the prescribing data that was presented, and the extremities of some of the outlying practices. GP2 counters this concern by calling on the 'supportive' model of collegial control, in

which colleagues are given the time and space to correct their own practice. GP1 challenges this model by asserting that he wants to ensure that such self-correction is actually occurring, to which GP2 repeats his support, but concedes that at the point in which any 'offending' individual should pass up the *opportunity* to address their own shortcomings, it would then become appropriate for the group to intervene to ensure that necessary changes were made.

GP1 – "Shouldn't we allocate somebody to look at both ends of the bell-curve? We might learn something from both ends. Are the questions being asked?"

GP2 – "We have got to give our colleagues the chance to take the initiative."

GP1 – "I want it asked, 'Have you asked the question?'"

GP2 – "The information is just coming out. Give them a chance to respond and then increase the pressure."

(Observational Data)

This extract suggests that it might have proved difficult for GPs to maintain the model of collegial control centred upon gentle persuasion once actual budgets and income are at stake. The prescribing initiative within the Total Commissioning Group was one 'real' example of GPs' willingness to apply resolute collegial control (rather than a hypothetical discussion about how things might work). The involvement of GPs in monitoring colleagues' practice actually proved to be very effective; a point that was mentioned in several of the meetings that I attended. The prescribing initiative was described as having been very successful in curbing 'excessive' prescribing behaviour

in a period of less than twelve months. Not only had the TCG prescribing budget been adhered to, but unexpected savings had been achieved. Thus, a year into my fieldwork the local actors involved in the TCG were discussing how the financial incentive structure would be implemented. These results exceeded the expressed expectations of both managers and clinicians.

The Health Authority Finance Director commended the results of the group at a Health Authority Board meeting *“Casterdale has traditionally been an over-spender. The work of GPs, the TCG especially, has been enormous. This should not go unnoticed.”*

The results of the prescribing initiative may simply reflect the effectiveness of the model of clinical governance as described by the GPs. The savings could have resulted from providing professionals with better information, which they subsequently used to address their own shortcomings. The comments of another board member later in the meeting would, however, perhaps suggest that the reduced spending was actually the result of a more ‘heavy handed’ approach.

Director of Public Health – “I know that we sent the hit-squad out on over prescribers!”

The Director did not clarify what he meant by ‘the hit squad’, but any idea of an authoritarian approach to control would not sit easily with descriptions of clinical governance as entailing little more than general collegial support. It would seem that it was advantageous for the GPs to present accounts that minimised the likely changes posed by their expanding regulatory role. In practice, however, GPs seemed to

prioritise protecting the continued availability of resources over protecting the individualistic professional autonomy of their colleagues.

5.4.2.2 Involving GPs in Controlling Secondary Care Practice

For most of this thesis, I have been concerned with the extent to which The New NHS was essentially concerned with the primary sector. Although much of the reform was framed in such a way, and certainly centred upon transforming the role of general practitioners and other primary health care workers, there were also significant aspects of the reform that reached across to the secondary and tertiary sectors. One such crucial change was the amalgamation of budgets for primary and secondary care, and the fact that the 'purse strings' for this general fund were being placed in the hands of GPs through the PCG structures. Historically, budgets for primary and secondary care had always been separate. However, beginning with the TCG (but to a much greater extent with the formation of PCGs) GPs were 'officially'⁹² being made accountable for a very sizeable amalgamated health care budget.

The control of these joint budgets would be a major part of the work of the PCGs and the issue of how specialists' practice might be curtailed was raised at several of my fieldwork meetings. The historic relationship and status differential (see Chapter 2) between GPs and their specialist colleagues seemed to create a sense of unease as to whether it would be possible for the GPs to maintain a system of collegial clinical governance would encompass both groups. In one of the TCG meetings, great concern was expressed over a report given from a recent joint prescribing meeting in

which hospital specialists claimed that they would be unable to control the prescribing practice of short-term medical staff (junior doctors). In the meeting that I observed, the TCG Forum members (all GPs) spent considerable time (nearly thirty minutes) contemplating what any anticipated overspends in the hospitals might mean for the availability of resources in primary care. Their key concern appeared to be avoiding such occurrences, but with little control over being able to do so. The effects of the transition from separate to combined budgets was also raised as a major concern by the TCG Forum members, and the imposition of a more restrictive system of regulation was proffered as the favoured solution.

GP1 – “There should be a three pronged attack. We need them (Hospital doctors) to sign up to a district wide executive committee.”

Field notes - A long discussion ensued about the relative powerlessness of the prescribing advisory body. This body had no official authority. The hospitals were not compelled to attend, or to abide by any of the decisions that were made.

GP1 – “Let’s hear them explain themselves in front of their executive (referring to doctors prescribing expensive alternative drugs).”

GP2 – “I feel that we need to take up this idea that you aren’t able to control staff who are there for six months. They are staff – employees of the trusts. They should do what they are told. It is crazy to admit that there is no control over staff. I don’t care if they are clinicians.”

⁹² I use the term ‘officially’ because the extent to which GPs actually had significant influence in

(Observational data)

There was quite a striking difference in the tone of this discussion relating to controlling *specialist doctors*, and previous discussions in which the focus had been on primary care. When discussing primary care, GPs tended to provide relatively restrained accounts of steering colleagues' practices towards improvements, and of empowering others to make responsible, professional decisions. The discussions regarding controlling secondary care were, however, framed quite differently. Hospital doctors should be confronted over any actions that are out of line with expectations, and they should be able to account for all unusual decisions that have been taken. Unlike the discussions about controlling GPs, there was no engagement with the idea of the particular needs of one's patients shaping appropriate practice, nor were any allowances anticipated for conditions of practice determining what might be considered to be appropriate care.

The GP's reference to the doctors as hospital 'staff' was also potentially interesting when considered in relation to the professional project of general practice. As outlined in Chapter 2, general practice has tended to prioritise its 'independent practitioner' status and the 'autonomy' that this provides in making its professional claim; GPs are not 'staff'. In this instance, however, the GPs assume quite a distinct stance in relation to formulating control over their clinical practice and that of hospital colleagues.

The structures for primary care that are outlined in *The New NHS* would allow a continuation of autonomous practice, supported by collegial information sharing and gentle persuasion. In contrast, local GPs were formulating a strict regulatory approach for hospital doctors. This chasm may reflect long standing frustration on the part of GPs, and result from underlying professional rivalry. GPs may be (at least on the rhetorical level) using this opportunity to carefully protect their claim to professional autonomy based upon their 'independence'- particularly when countered with an opportunity to impose increasing restrictions for their secondary care colleagues.

At a PCG meeting several months after the discussion that I have just described, the same kinds of issues were raised once again – and appeared to be just as salient. The following extract is taken from my observation of a fairly heated dialogue between three GP board members from one of the PCGs. The Chair of this PCG⁹³ raised the issue of the accountability and effectiveness of an existing 'joint prescribing committee' with a local Trust⁹⁴. The board member who had attended the last meeting of the prescribing committee (GP2), presented a perspective least likely to cause offence to secondary sector colleagues. One of the other GPs (GP3) was, however, highly sceptical of the hospital doctors' account, particularly specialists' claim to be unable to control colleagues' practice. At the end of the discussion, however, the PCG members accepted a concessionary based upon professional understandings.

⁹³ A GP

⁹⁴ A structure in which representatives from the relevant Trust and the PCG would collaborate in making decisions that would then be binding across both the Trust and the PCG.

Chair – “At the first discussion that we had about this, we expressed concern that the board (the prescribing committee) should not be constructed so that the decisions were being taken by people who were not accountable for them. The Trust is taking decisions that we can’t afford.”

GP2 – “Yes, but the alternative is a committee that stops functioning because one group has no power. Also, we could make decisions that they can’t live with or afford. If we don’t give them votes they will not come along to the meetings, and they will not abide by the decisions made there.”

GP3 – “I am a little concerned by your terms of reference. The Executive Committee of the Trusts should deliver the same level of accountability for making sure these decisions are implemented as we do. If a drug is deemed better then that is what is prescribed.”

GP2 – “The argument was that an anaesthetist on the committee cannot make a consultant cardiologist change his prescribing habits. There is not a clinical governance framework within the trusts like there is for us. Therefore, we thought that it would be best to start with the new drugs. Prepare a sort of formulary or guidelines.”

GP3 – “There are guidelines coming out all of the time now, and they are compiled by primary and secondary care specialists. Why can the Trusts not deliver compliance to these? This is central to the collaborative commissioning mechanism.”

GP2 – *“We are happy to deliver this. We have a chain of command to deal with a maverick GP. They do not have that.”*

GP3 – *“They do! They just don’t use it. There is a hierarchy within the Trusts. I am not happy with a situation where the representative on the committee says that it is impossible to deliver compliance.”*

GP4 – *“In the US, the way that they have achieved this is through the HMO [Health Maintenance Organisation] contracts. There are agreed standards in relation to prescribing within the doctors’ contracts.”*

Chair – *“That would involved totally new consultant contracts. We aren’t going to get that.”*

(Discussion about introducing prescribing into contracts.)

GP2 – *“If primary and secondary doctors are prescribing differently then there is really no point in having this committee.”*

Chair – *“Lets take an example- diuretics. What would this committee do about it?”*

GP2 – *“We could do several things. We could produce guidelines, and we are pressing that all guidelines should include an element of prescribing guidelines.”*

Chair – “Perhaps the way to give this teeth is through contracting. What do you think, (GP3)?”

GP3 – “I hadn’t been thinking about this in terms of commissioning. I do not think that we should get this specific. What we need is a gentlemen’s agreement that prescribers will behave responsibly.”

GP2 – “We thought that the best way to do that was to start with new drugs. We thought that it was unrealistic to try to get people to abandon using their favourite old drug.”

(Observational data)

GP2’s position regarding this committee should perhaps be understood in relation to his previous experience as the Chair of the TCG, and his present position as the Chair of the Collaborative Commissioning Mechanism. He had no more official power on this PCG Board than any of the other members, but he asserted his opinion quite strongly, and the new PCG Chair (who is also experienced in dealing with Trusts) seemed to often defer to his opinion. The GPs had officially been given control over, and responsibility for maintaining an amalgamated budget. Interchanges such as the one above suggest that the GPs were expending considerable effort to establish this control with hospital doctors, and also working to construct a strong rhetorical foundations for this work within the bounds of the newly forming PCG structure.

It would seem that although the GPs may have approached controlling hospital doctors quite differently from how the TCG and PCGs described tackling such issues in the primary sector, in practice the measures employed were very similar. Existing

professional relationships played a large part in shaping the new paradigm of clinical control as administered at the local level.

5.4.3 A mediating factor: control over vital information

Much of this chapter has focused on the ways in which GPs were able to fashion the clinical governance initiatives in such a way as to either serve their own agenda, or at least prevent them from having a significant negative impact. The data, however, revealed at least one distinct limitation to GPs' ability to gain control over the implementation process; GPs had very limited access to sources of information that they deemed essential to the effective control of their new clinical governance tasks. Several of the control initiatives proposed within the reform measures relied upon having access to good quality information. Evidence-based medicine was one such example, requiring the necessary data upon which to base decisions. Furthermore, in order to introduce measurable targets and goals, it is important to have the necessary information to establish a baseline by which progress may be demonstrated.

One of the primary issues that was discussed by the GPs involved in both the TCG and the PCGs was how necessary information might be acquired. The issue of accessing and sharing information proved to be quite problematic. The Health Authority seemed reluctant to share information with the TCG and the PCGs, and the application of such information to commissioning tasks was seemingly restricted based upon anticipated sensitivity among GPs in relation to sharing practice information.

Historically, information within the NHS has been a heavily protected commodity⁹⁵, and general practice has been particularly sensitive to proposals of increased information sharing. The ethos of GPs as 'small businessmen', and the competitive relationships between local practitioners, have both served as barriers to professional colleagues sharing information. Within such organisational structures, practice information is commercially sensitive, and it is not unsurprising that individuals should seek to protect it wherever possible. The sensitivity of practice information had been heightened in recent NHS history with the Conservative government's (1990) *Working for Patients* reforms. These measures emphasised, rather than diffused competition between practitioners.

One of the Health Authority implementation managers drew particular attention to the difficulties that would be faced by the PCGs as a result of this culture of competition between GPs, and their general reluctance to share important information.

Implementation manager – "That is one of the things that needs to be looked at is where practices stand already, what staffing for example they have as opposed to a practice of a similar size. But, at the moment there is a confidentiality issue that has got to be resolved about the sharing of individual, practice based information because GPs are self employed. They have their own little business in a way, and so there are some data collection issues as well. It doesn't mean that you can automatically share specific information."

(Interview data)

⁹⁵ The prime example of such protection being that afforded to patients' records.

The PCG implementation managers described the 'small business' culture as being a challenge to the reform's objective, and as something to be overcome if PCGs were to be able to effectively monitor and control practice.

Implementation Manager - "The information thing is going to be quite difficult. We want the PACT 4 data (practice prescribing data) for our PCG, and the Health Authority is quite reluctant to give it because of the confidentiality thing. So there will be a lot of pushing around there..... I think that we as a PCG are going to say, 'I am sorry, but we have got to have it.' And in whatever way we can get some sort of signature from each practice that is ok."

(Interview data)

The culture of professional rivalry was still evident in Casterdale during the fieldwork period. The data, however, also suggest that although the GPs actively involved in the TCG and PCGs recognised that their colleagues were likely to resist measures that imposed sharing widespread sharing of practice data, they recognized that this was a necessary part of developing a collaborative culture. One GP stated that only once a collective culture was established might the prospect of sharing practice information be perceived to be less threatening. He predicted that *given time* (and if given the freedom to make the decision themselves), GPs would become comfortable with open comparisons being made between their practice and that of others. He also envisaged that such open comparisons would not only be more useful than anonymised audit, but that GPs would eventually find them less threatening.

Commissioning GP – “But there are issues around – one of the issues raised is that the people sitting on the board are also local GPs. Therefore they will have access to information about local general practice, which rolls out to issues about whether you actually make that information public. My guess is that that is where it will go – but it may take a year or two to get there. People will say that they would rather everybody knew, rather than just the board.”

KC – “Yeah, and I could know-“

Commissioning GP – “yeah, I could know next door’s – that is quite a cultural shift. General practice tends to be quite overprotective about information. The other way that that will happen is through the clinical governance – looking at prescribing, referral rates, that sort of thing. Doing that through having joint meetings between practices, at which you anonymise the data, and allowing the meetings of GPs themselves to say, ‘We don’t need to anonymise.’ Rather than say from on high that this is going to be available. People are saying – B on there is me, I don’t care if everybody knows that. That is how you get that – grass roots. Until you have actually got the sharing of information between practices, rather than the PCG, it is very difficult to get change.”

(Interview data)

The formation of the TCG, and subsequently the PCGs, posed potential challenges to traditional notions about who had legitimate access to information, as well as the use to which such information could be put. It did not, however, appear that the institutions and actors (largely centred around the Health Authority) currently in possession of such information, were particularly willing to yield it. In the meetings

that I observed, the GPs expressed concern that the power of the Health Authority was such that if they did not want to concede control, the GPs could do little about it.

Members of the newly forming PCGs often expressed frustration in relation to their difficulty in accessing data that they saw as important to doing what was required of them in their new role. The struggle for access to information was particularly apparent in relation to practice-specific prescribing and referral data. During the implementation period, the GPs frequently speculated about why they were having such problems over practice data, as well as how such problems might be overcome.

GPs relayed accounts of historic struggles with the Health Authority over access to data - even regarding their own practice. One GP associated his difficulty accessing data with his ability to determine if his practice was being allocated a 'fair share' of the resources. He then asserted that the Health Authority used the practice of withholding practice information as a mechanism by which to tighten their control over the GPs.

Ex-fundholding GP – “One of the difficulties that I had was that we were not ever getting a fair share of the cake. You must have heard me say that on numerous occasions. You would ask the Health Authority, ‘How much are you spending on our patients?’ and they would say, ‘You know, obviously we can’t work it out on an individual practice basis.’ And then along came fundholding..... I was a cynical man, I knew that I might not get the answer, but at least I would put some evidence on my argument –

‘Please Mr. Health Authority, how much are you spending on our patients?’

'Can't tell you, doctor.'

'I will become a fundholder.'

'You are spending 183 pounds per patient per year''

(Interview data)

The GPs did not, however, describe either the introduction of the TCG, or the PCGs as having done very much to improve their ability to extract data from the Health Authority. The following extract is from a TCG Forum meeting several months after the formation of the initiative. The GPs were reviewing their progress in relation to accessing prescribing information from the Health Authority. In previous meetings, GPs had expressed frustration over the time that it was taking for the Health Authority to transfer the requested data to the TCG.

Chair – "There has been some progress."

GP2 – "We are nearly there. We haven't had to have any tantrums. 'Mike' (the new Information Technology manager) has produced an Access programme. The graph is more accessible than before. I have drafted some explanatory text to go out at the same time as the data. I will circulate that now, and I would appreciate any comments. We want to get things going fairly quickly now. It gives a breakdown for age, gives your practice versus those in the district, and gives 95% confidence levels. We anticipated that this will be available on request to GPs rather than distributing it to all GPs as not all GPs will want this. I am concerned that if this level of

information were to go out without explanation then it might be confusing (discussion of what level of information to send out to all GPs. There has been a distinction made between level 1 and level 2 data. Level 2 data is more complex/detailed.)."

GP2 – "Mike is a good chap. He has already done many good things."

GP3 – "How quickly did all of this happen after we had the tantrum?"

Chair – "All credit to the IT group."

(Observational data)

The difficulty accessing information seems to have persisted beyond the introduction of PCGs. In a later interview, another PCG Chair described the difficulty that his PCG was having in accessing information held at the Health Authority that was judged as important for the effective function of the PCG.

Chair - "We have received a health profile of the PCG from public health which provided us with some very basic data about referring and prescribing and use of hospital services and morbidity. It is fairly sketchy and big scale stuff and we really need much more detail before we can put good use to this, in my opinion. We need data down to the practice base, rather than simply across the PCG."

KC – "Do you not have that at the moment?"

Chair – “It is available but we don’t have it. It is in public health. I met with our public health link person last week and talked to them about what information we would like and she is going to try to dig it out for us.”

(Interview data)

5.4.3.1 Summary

The control of practice information emerged as important for the shifting relationship between GPs and the Health Authority both preceding and during the PCG implementation period. The culture of general practice has historically been such that sharing practice information between individual professionals had been kept to a minimum. Health Authorities collected and controlled all necessary data. The involvement of GPs in initiatives such as the TCG and PCGs had, however, created conditions in which GPs became increasingly concerned with acquiring such information.

At several points during the fieldwork, the GPs’ expressed frustration about the Health Authority’s apparent reluctance to share information with the GPs, or even to acknowledge that such cooperation was necessary. The Health Authority’s control over information was seen as a source of considerable power. The ensuing struggle for information between the GPs and the Health Authority was a source of tension, and seemed to reflect both parties’ belief that control over information would strengthen their position within the new structures. The Health Authority appeared to have the advantage of possession (being 9/10s of the law), and their hesitant transfer of information proved to be a significant obstruction to GPs’ ability to control the progress of the reform initiatives.

5.5 Discussion: Clinical Governance within ‘The New NHS’ as a reformulation of the relationship between the Government and the GP Profession

“Primary Care Groups will develop primary care by joint working across practices; sharing skills; providing a forum for professional development, audit and peer review; assuring quality and developing the new approach to clinical governance; and influencing the deployment of resources for general practice locally.” (The New NHS, 1997: 34)

“Primary Care Groups will be expected to help primary care professionals to enhance the quality of their care. There is much on which to build. Clinical audit is now becoming well established in general practice and the NHS executive is working with the profession to develop indicators to assess the effectiveness of primary care at national and Health Authority levels.” (The New NHS, 1997; 41)

I began this chapter by outlining how *The New NHS* can be understood as an initiative to improve government control within the health care arena. I explained that the cost of providing health care has continued to rise, without seemingly meeting the expectations and demands of the population, and that successive governments have set out to ‘tame’ the voracious animal that is government health care spending. In such measures, there has been a tendency to focus on the power of the medical profession as an explanation for the seeming ‘inadequacy’ of government control over the provision of health care (Calnan and Gabe, 1991). Thus, an augmentation of state

control has often been presented as requiring little more than a dismantling of professional powers. Such a position is, however, flawed in that it fails to acknowledge that governments repeatedly call upon professional regulation as a tool by which to expand their jurisdiction without succumbing to overburdened responsibilities. It also does not take into account the importance of the role that can be played by professionals due to their high status, to act as 'promoters' or 'propagandists' for reform measures; often capturing essential public support (Hughes, 1971).

The New NHS does not fall prey to such an underestimation of the importance of the medical profession for continued state control. The 1997 reform initiatives can be understood as an attempt to augment central control over clinical practice (and thus the use of resources), while simultaneously strengthening professional responsibility for the provision of care. In addition, the reform measures were framed in such a way as to provide perceptible opportunities for professional advancement for the government's target audience for reform implementation (GPs), thus enticing powerful professional co-operation rather than resistance.

The New NHS introduced a strengthened system of national structures through which the delivery of care would be closely followed and accessed, while at the same time emphasising the role of local structures, and of professional networks in particular, in monitoring clinical practice. The formation and development of PCGs involved initiating structured systems of professional self-regulation, but also entailed strengthening systems of collegial control over clinical practice and the devolution of financial 'responsibility' to local professionals.

To conclude this chapter, I will consider how the reform initiative was structured such that government control would be strengthened without alienating general practitioners. In so doing, the necessity of more active government involvement in the provision of health care might be avoided. My analysis acknowledges that this reform implementation was an interactive process between two powerful actors – the GP profession and the government. The outcome of the reform would be largely determined by GPs' interaction with the initiatives, which in turn rested on GPs' perception of the opportunities or challenges posed by the reforms, their engagement with the new ideas, and their ability to shape these for their own purposes.

5.5.1 *The New NHS* serves to challenge GPs' control over clinical practice

The reform initiatives as outlined in this chapter certainly had the potential to impinge upon the routine clinical practice of general practitioners. The reforms specified that clinical practice would need to be more directed, more open to scrutiny and subject to standardised measurements. Such 'interference' has generally met with strong professional resistance; Hughes (1971) proposed that "Perhaps the commonest complaint of people in the professions which perform a service for others is that they are somehow prevented from doing their work the way that it should be done." (p. 309).

The advent of PCGs also involved a shift in focus from individual to collective notions of autonomy. 'Self' regulation is becoming portrayed in relation to the collective rather than the individual 'self'. The following interview comment made by one GP suggests that the present reforms essentially prioritise collectivity and reflect

upon the weakness of existing structures of self-regulation. The effects of such a shift for the profession are not, however, yet apparent.

Local GP active in the RCGP - "So I think that we are seeing an erosion of individualism towards collectivism. But if I can just move on for a second to professional self regulation because this is proclaimed as the golden age of professional self regulation. And, as you are aware, professional self regulation has been a theory but not a practice for the last few hundred years."

(Interview data)

Johnson (1972) established that professional prestige rests upon the opinion of one's peers and the evaluation of one's colleagues. The potential power of collegial mediation has been recognised and incorporated into the system of informal professional control, upon which the NHS has relied since its inception.

Unfortunately, 'informal' collegial regulation has not always been as effective at controlling professional practice as had been expected, and this failure has served to challenge public confidence in both the medical profession and the NHS system. The current reforms can be interpreted as seeking to 're'-establish (assuming that control actually existed previously) greater control over financial and clinical decisions in the NHS without having to abandon the reliance on professionals to deliver practice in which the public has confidence.

The extent to which the reform measures would actually succeed in controlling individual GPs' practice, or in promoting more active and effective professional regulation were primarily matters of speculation during my period of fieldwork – much of which was conducted before or during the PCG 'shadow period'. Fortified

systems of collegial self-regulation *were* being constructed, and local actors predicted that these would eventually restrict the freedom of individual practitioners. One Health Authority Implementation Manager suggested that he hoped professional regulation would prove more effective in controlling GP practice than previous attempts to 'externally' regulate.

Health Authority Implementation Manager - "I think that this is a way of making GPs more accountable. The Health Authorities haven't been able to. The Family Health Service Authorities haven't been able to. Right, let's give it to the GPs, and make them do it. Make them self regulate. This makes them work together for the first time."

(Interview data)

The extent to which the new structures to effectively control practice was, however, in no way clear. These reforms may have altered working practices and professional relationships at the micro level, and may even have been successful in affecting meso-level structures between the medical profession and the government in relation to controlling the NHS. Still, it can be argued that the impact that these changes will have on the power of the medical profession will be minimal (Harrison and Ahmad, 2000). The relatively abstract structures and the everyday working practices sit upon an underlying paradigm of the biomedical model of health and health care. So long as this model remains unchallenged, doctors retain extremely powerful positions as experts, both in defining the realm itself, as well as in providing treatment.

5.5.2 A rhetoric of reassurance

“Primary Care Groups comprising all GPs in an area together with community nurses will take responsibility for commissioning services for the local community. This will not affect the independent contractor status of GPs.” (The New NHS, 1997: 22)

“New Primary Care Groups will be established in all parts of the country to commission services for local patients. They will have control over resources but will have to account for how they have used them in improving efficiency and quality. They do not affect GPs’ independent contractor status.” (The New NHS, 1997: 32)

The White Paper made repeated assurances that the proposals would not directly threaten GPs’ independent practitioner status. Better clinical control and standards would not depend on dismantling the existing professional structures. It seems likely that these assurances were formulated so as to avoid alienating a profession that had previously been effective in derailing reform initiatives⁹⁶ (Klein, 1995; Mays, 1997; Webster, 1988), and who was so clearly central to the success of this one.

Whilst the reform rhetoric was structured to reassure, rather than alarm the profession, it did not sit particularly well with some of the reform initiatives that were actually being introduced. As described in the previous section, several of the reform’s proposals could easily be interpreted as threatening to GPs’ professional agenda. The reform’s stated objective of establishing equality in the NHS is one example in which potentially significant changes at the level of individual clinical practice, as well as

⁹⁶ See Chapter 2.5 for a fuller discussion – particularly the influence of general practice in shaping the 1946 NHS Act, so that plans for Health Centres with salaried doctors had to be abandoned.

with regards to the nature and strength of professional regulation were being introduced.

While reform rhetoric is being subjected to such 'critical' scrutiny, it is perhaps only fair that similar attention should be afforded to the ideology of professional autonomy that it is said to undermine. Perhaps the idea of 'professional autonomy' is better understood as professional myth, rather than a realistic 'baseline' for comparison with the current changes (Wolinsky, 1988). A call to an abstract notion of 'autonomy' (that is likely never to have actually existed) may have served more as an effective way for GPs to resist any changes that were even potentially threatening (on whatever grounds) than as an organising principle.

5.5.3 Professional incorporation into the 'inevitable' augmentation of control and accountability.

"The Government will continue to look to individual health professionals to be responsible for the quality of their own clinical practice. Professional self-regulation must remain an essential element in the delivery of quality patient services." (The New NHS, 1997: 59)

The current reforms seem to have been formulated to incorporate, rather than alienate the GPs who would be central to their implementation. At the same time, the reforms clearly laid out the government's argument that increased control over clinical practice was essential in order to achieve greater efficiency and equality within the NHS. *The New NHS* rested on an assumption that there would be widespread public support for measures setting out to tackle the existing 'two-tiered' service, with its in-built inefficiencies and lack of accountability.

The reform proposals offered local professionals central roles in the reformed structures; GPs were allowed to retain control over systems of regulation, and were given extended roles in relation to resource allocation. In return, they were expected to accept and implement strengthened and more accountable regulatory systems. Harrison and Ahmad (2000) argue that the power dynamic between the government and professions will always be relatively one-sided. Any bargain struck in which professional autonomy is granted in return for a profession's agreement to take responsibility for a particular area of the state's domain can be downgraded, if and when it serves the government to do so.

Increasing GPs' involvement in managerial tasks was central to the reform initiatives. Such involvement served to draw professionals further into the 'web' of the NHS, thus reducing the likelihood of effective objections to future reform measures. The White Paper also framed augmented professional involvement in the management and regulation of the system as somewhat of a 'last chance' for the profession. Greater control over clinical practice was presented as a non-negotiable objective; professionals could choose either to embrace and control it, or submit to external supervision.

The opportunities posed by taking up PCG board memberships appealed to many of the Casterdale GPs. Most of the leading local professional 'personalities' were elected to positions as board members and Chairs. The creation of a layer of 'managerial' GPs (the PCG boards) facilitated the introduction of particular control initiatives, and was a potentially effective way by which to gain the support of GPs who had historically been resistant to reform. Thus, a 'hierarchy' within the professional structure was formed, where previously there had been relative homogeneity. This

may be interpreted as an attempt by the government to instigate a 'divide and rule' policy within the profession. Not only might GPs find it more difficult to resist control measures that are managed by professional colleagues, any such resistant professionals had also been 'relieved' of many of their most experienced leaders.

The establishment of PCGs would also appear to bind the two 'opposing' elements of managerialism and professionalism together in the form of PCG boards. Flynn (1992: 87) claimed (in relation to health services management) that "*The enduring issue is that of clinical autonomy versus managerial control.*". Although his analysis relates to an earlier set of reforms, the observation that doctors were being co-opted into management by appealing to the indisputable value of 'a pursuit of quality', is applicable to this restructuring. Once a group of GPs is heavily involved with the management process, it may be possible to use these individuals to mediate between the government and management and their professional colleagues. Such mediation is potentially crucial for the success of current or future initiatives.

5.5.4 Moulding the initiatives to serve the professional agenda

Thus far, this discussion has tended to position general practitioners as somewhat passive recipients of the reform initiatives. The data suggest, however, that the GPs played an active and important role in shaping the implementation of the measures – often successfully incorporating potentially challenging changes into furthering their own professional claim.

At the very least, GPs appear to have been relatively successful in using their central position in the implementation of reforms to minimise the impact of measures that

they deemed to be potentially challenging. GPs in some areas were able to undermine the implementation measures to the extent that although the language of reform remained intact, there was actually little 'real' change. One such issue was the focus on the augmentation and formalisation of professional self-regulation. Influential GPs (those on the TCG Forum and subsequently the PCG boards) tended to present an interpretation of this expectation as an expansion and development of existing systems of 'sharing of good practice' and collegial support. Such interpretations do not incorporate a particularly developed notion of collective accountability, nor do they entertain ideas of collegial sanctions or professional hierarchies. Health Authority managers would also appear to have adopted the model of self-regulation as peer pressure rather than the management of more formalised control structures on the basis that such interpretations are more realistically effective.

Public health consultant - "It will be peer group pressure, not the Health Authority saying, 'Look, there is no money – stop what you are doing.' They will be looking at each other – which is quite a different kettle of fish from a fundholder being scrutinised at year end by the Health Authority on performance against a business plan. It is only them sitting there being scrutinised."

(Interview data)

Beyond GPs' ability to minimise any potentially harmful effects of the reform initiatives, the data also suggest that the proposals have been largely in line with pre-existing professional developments. There was considerable evidence that GPs had been working to strengthen mechanisms of effective self regulation before the advent of PCGs. *The New NHS* acknowledged the development of systems of audit in primary care, and one of the GPs interviewed early in the fieldwork process described

a pre-existing, locally developed (but informal) 'auditing' system that had been established between local practices. Within such locally formulated structures, GPs had become willing to share data and good practice with one another. This system of informal audit was presented as one in which clinical governance was built upon GPs helping rather than monitoring one another. The idea that traditional notions of unchallenged clinical and financial autonomy were being challenged and undermined before the advent of PCGs was echoed by another GP⁹⁷.

GP active in the Royal College of General Practitioners - "I think that we have already become more accountable over the last few years. We are accountable much more to our patients. People understand more and are not willing to have the wool pulled over their eyes."

"Increasingly, the idea that somebody can say, 'Get stuffed, I am a GP and I will do what I like to do' has already been eroded. It is already gone. It simply hasn't been codified in law."

(Interview data)

Klein (1995) suggests that the medical profession has generally seemed willing (when prompted) to restrict the clinical freedom of individual practitioners in order to protect collective professional autonomy. The inevitability of some kind of professional 'sacrifice' seems to have been accepted by many Casterdale GPs. Many had already become engaged with informal audit systems that had been locally and professionally developed. It might therefore be argued that *The New NHS* initiatives

⁹⁷ It is possible that these GPs are basing their opinions of previous levels of clinical freedoms (often before they entered practice) on mythical accounts of the 'glory days' of the profession. Levels of freedom may be much higher in hindsight than they were perceived to have been at the time.

added little to the system of collegial control beyond a process of formalisation and restructuring of pre-existing locally formulated and implemented mechanisms.

Again, the perspectives presented here have all portrayed GPs as defensively receiving these reform measures, rather than proactively seeking and embracing them. It is, however, also possible that some GPs will have approached increased involvement in management as an opportunity to enhance professional autonomy. The increasing direct involvement of GPs in the managerial realm can be seen as challenging to traditional professional structures, or it may be seen as potentially strengthening the position of GPs by facilitating the augmentation of professional self-regulation, upon which a stronger claim to professional status may be made⁹⁸.

Measures that strengthen systems of collegial control may be interpreted either as threatening to professional autonomy or as being central to any attempts to strengthening it. Professional power rests on being able to create expert authority based on a high level of knowledge, and then translating this knowledge base into moral authority (Halliday, 1987). With only weak self-regulation there is a significant chance that the right to self-regulate may be lost, and therefore any opportunity to demonstrate effective self-regulation can contribute to retaining professional autonomy and status (Wolinsky, 1993). The development of systems of evaluation may be seen as useful devices for enhancing professional status; accountability structures enable professionals to demonstrate adequacy and control through scientific methods that are highly influential with the general public.

⁹⁸ Flynn (1992) found that the 1990 reforms actually served to empower doctors, and concluded that management structures control associated with State policies need not necessarily be viewed as

One GP who was interviewed expressed his hopes and fears for the more intense focus upon clinical governance in the following way,

GP - "I think, one of my main fears is that clinical governance is going to concentrate on risk management – the edge, the bad apples. It is not going to be, initially at least, about quality assurance and moving the whole bell-shaped curve off to the right."

(Interview data)

The 'fears' expressed by this GP provide insight into what he hopes that clinical governance might deliver. He does not express unhappiness with the introduction of clinical governance. His hope is that the system could deliver a higher quality and more standardised structure to general practice that would have the potential to strengthen the professional claim of this group. His trepidation is that the reforms will not bring an improvement in the general quality of practice.

Professional authority can be seen to rest on public confidence that professional practice will be shaped by a common culture based upon a sense of vocation, altruism and the prioritisation needs of the client (Saks, 1998). The extent to which GPs are able to demonstrate such traits seem likely to be enhanced through these reform initiatives. The new clinical governance structures can be understood as a formalisation of locally and professionally-driven mechanisms of collegial control. This formalisation may serve to publicly demonstrate that attention is being paid to

professional responsibility and accountability, and this may serve to challenge the notion that GPs protect, rather than monitor, one another.

In order to rebuild trust, it is essential for people to perceive the new control structures as being driven by quality incentives, rather than cost-saving goals. Trust would only be further damaged by a system in which GPs' decisions were perceived to be determined by cost implications rather than the patient's needs. These data demonstrate that through the implementation of reform initiatives such as *The New NHS*, responsibility for the success of this portrayal in re-establishing the legitimacy of public trust is being held jointly between the government and GPs at the coal face.

6. Creating and Maintaining Consensus within Policy Implementation

“When an observer looks behind the façade of formal institutions to the way they are realized in practice, he or she gains a considerably more complex and precise view of the exercise of power or influence than is provided by official charters, tables of organization and legislation.” Freidson (1993a: 56)

6.1 Introduction

My research provided a window into the micro-processes of policy implementation and organisational change. In this chapter, I will suggest that there are many reasons why one might have anticipated the implementation of this reform initiative to be characterised by conflict between GPs and local NHS managers. However, contrary to expectations, my data reveal a complex portrait of co-operation, consensus building, and only occasional conflict between different groups of local ‘stakeholders’.

Local reactions to the reform initiatives were shaped by a widespread expectation of change with the advent of the new government. The Labour Party’s election manifesto outlined plans for NHS reform, promising to end the ‘two-tierism’ of fundholding, and the excessive bureaucracy of the internal market. The manifesto did not, however, include details of the replacements for these structures. Furthermore, the eventual product of the manifesto pledges (PCGs) received a critical reception from both Conservative GPs, and also from clinicians who had supported Labour’s promise to reform the NHS.

After the release of the White Paper, there was relatively widespread GP resistance to the reform measures. I observed this resistance through the national professional press, as well as through discussions occurring on a national GP mailing list (Clegg, 1999) and in debate occurring locally in Casterdale. GPs predicted wide scale professional non-compliance with the initiatives, and there was some discussion of a general resignation. GPs' hesitancy was clearly illustrated through the account given by the Chief Executive of the LMC of general professional unease around the White Paper proposals. The LMC Chief Executive expressed concern over whether enough (or any) GPs would put themselves forward for positions as PCG board members.

LMC Chief Executive - "And they are starting to have these meetings and there was one the day before yesterday and one of the members rang me yesterday and he said, 'Not one GP is willing to stand. There are four GPs who are quite experienced who are thinking about it.' They are thinking in terms that they could be persuaded to – but they are not happy about it. And their practices are not happy about taking the risk of putting themselves forward in the absence of certainty."

(Interview data)

Professional resistance to the reforms was significant in terms of both the production and implementation of the initiatives. Throughout the history of the NHS, GPs have been fairly effective in resisting reform measures. Initial concerted and widespread professional resistance to the 1997 initiatives was therefore a likely motivating factor for

policy makers to work to incorporate rather than alienate GPs. History would suggest that professional acquiescence to reform initiatives has often proven key to attaining official goals and targets.

By the time the White Paper was implemented, GPs had generally conceded (at least superficially) to the reform proposals. The predicted national programme of resignation had not occurred, and Casterdale GPs had filled all of the available seats on PCG boards. I do not intend to discuss how this 'turn around' was achieved. Rather, I will focus on potential foundations for both the establishment and maintenance of consensus and co-operation at the local level between actors with different agendas. I will also reflect on instances in which consensus building and co-operation broke down, and both inter and intra-group conflict ensued. Moreover, I will examine what such 'negative cases' might contribute to an analysis of the process of policy implementation.

By way of introduction to the analysis of the consensus building and co-operation within Casterdale, it is first important to present a consideration of why one might have predicted conflict, rather than co-operation, between local GPs and managers.

6.2 Why might one not expect to find co-operation between managers and doctors?

The relationship between professionals and managers is seldom conceptualised as a harmonious one. Indeed, the history of the NHS has often been described as one of near-constant conflict between the policy makers and the medical profession. Considerations of health care systems have frequently emphasised the divisions between managers and health care professionals when accounting for the limited success of reform initiatives (Ham,1992).

Managers and professionals are sometimes conceived as being at odds with one another because they are seen to hold fundamentally different underlying objectives and operational agendas. Such theories build upon assumptions that doctors and managers have different jobs to do – and these jobs often contradict, rather than complement one another.” Dopson (1996: 177), for instance, contends that “*doctors and managers have very different interests and perspectives which make the establishment of harmonious relations difficult to achieve.*” Flynn (1992) also asserts that there are significant differences between doctors’ and managers’ objectives that will contribute to conflict.

Analysis abounds as to how to account for such different objectives and agendas: It may be argued that the philosophical underpinnings and cultures of the two groups (doctors and managers) are fundamentally different, and are therefore necessarily oppositional. Coombs (1987: 401) asserts that doctors and managers “*inhabit sharply different cultures with different values and perspectives. The language of symptoms, treatments and prognoses does not translate easily into the language of budgets and efficiency.*” From Coombs’ perspective, the two groups do not even possess a common language that would

allow them to effectively communicate, and would serve as a basis from which to collaborate. Dopson (1996) concurs that different underlying philosophies shape relations; doctors and managers hold different 'thought styles' that lead them to think differently about health care provision and prevent the establishment of effective communication.

Furthermore, Drummond (1987) maintains that the definitions of 'effective care' held by the two groups are very different and that these contrasting positions support alternative approaches to health care equity. Doctors hold an *individualistic* perspective of health care (to provide the best care for each individual patient), while managers hold a more *utilitarian* position (to provide the best overall care for the population). Drummond also contends that consensus might be attained through the elimination of ineffective procedures, the replacement of high cost treatments with equally effective low cost ones, and dialogue as to the trade off between cost and effectiveness.

The following description given by a Health Authority senior manager illustrates the extent to which the perception of the underlying differences between managers and GPs has permeated local level opinions. He describes the two sectors as inhabiting completely different worlds, and therefore finding co-operation a great challenge.

Health Authority Manager – "A local doctor and I gave a joint presentation (in relation to the future of PCGs). He imagined what the big organisation (the health authority) was like and he presented the health authority perspective. I presented the GP perspective -

the big structured organisation used to working in an accountability structure, used to handling decision making processes and so on, comes together with the small, autocratic, the doctor being dictator in his own realm – and these two come together.”

(Interview data)

Beyond holding different philosophies as to health care provision, managers and professionals are commonly expected to clash because managers represent ‘bureaucracy’, which is seen as fundamentally threatening to the professional project (Miller, 1970). The bureaucratic-professional conflict thesis is well established within the sociological literature. It is based on Weberian notions of legal-rational authority, and its apparent incompatibility with professional autonomy (Flynn, 1992). Professionals are trained and socialised to think of their work as primarily entailing full responsibility towards a client/ele, and subject only to peer review, rather than bureaucratic control. Thus, GPs (acting as professionals) will resist becoming involved in managerial tasks (Greenfield and Nayak, 1996), largely because such work is seen as contradictory to role expectations. Flynn (1992: 53) predicts that the rationalisation of medical work processes and managerial initiatives within health service delivery will necessarily involve a subordination of, or an accommodation to, professional autonomy.

Larson’s (1980) analysis of reform rationalisation is largely concurrent with that of Flynn. She states that, *“Under financial pressure, the focus of managerial policy is clear, however undecided or unpredictable its strategies: costs must be reduced and/or productivity must be increased. This imperative inevitably threatens the prerogatives of*

privileged worker.” (163). Larson (1977: 190), however, also challenges the dualist approach to professions and bureaucracy that set up these two ‘forces’ in positions of unavoidable conflict. She claims that such an approach is often based on an oversimplistic understanding of professionalism. Bureaucracy and professionalism are two subgroups of an overarching system of rational administration, and are often interdependent aspects for attaining and maintaining appropriate levels of social control (Larson, 1977: 191).

Incorporating the likelihood of professional/managerial conflict, such difficulties are sometimes presented as likely to intensify during periods of organisational change (Flynn, 1992). Organisational change contributes to great uncertainty, and poses opportunities for existing relationships between different groups to be challenged. During periods of upheaval, managers may seek to gain greater control over professional action (Flynn, 1992), and any meaningful differences between the groups’ objectives and interests may be exploited in attempts to exert greater control. According to Flynn, organisational change within health care services involves managerial attempts to constrain and redefine medical autonomy, and tension between the two groups inevitably results. From this perspective, one would predict that the preparation for, and implementation of, *The New NHS* would be a time of extraordinary professional-managerial struggle and tension.

If conflict between professionals and management is pervasive within health care provision, then one would expect such conflict to dominate local interaction. The

interaction in Casterdale, however, did not exhibit such overt conflict. Rather, there was evidence of considerable effort on the part of all local actors to create and maintain consensus and co-operation. Before considering the strategies through which consensus was built at the local level, I wish first to introduce possible motivating factors for working towards consensus, rather than conflict.

6.3 Managers seek to create and maintain consensus

Although professionals are frequently portrayed as protagonists during periods of reform implementation, local managers are also key to directing this process. Because of their role as mediators of reform rhetoric and initiatives, managers are particularly influential to the development of a sense of either collaboration or conflict in the local setting. The Casterdale data suggest that Health Authority managers worked to establish and support collaboration with GPs. In the next two sections, I will discuss the managerial agendas that were potentially furthered by such actions.

6.3.1 Consensus facilitates 'Trojan Horse' policies

Managers have commonly been charged with the smooth local implementation of centrally formulated reform measures, and gaining operational consensus is an important part of such a task. Government initiated policy objectives are unlikely to be effective without the co-operation of influential local actors. It would seem, however, that professional incorporation often requires a greater level of ambiguity during the local development of policy than might be judged as ideal.

With such 'ambiguous incorporation', the more that people are involved in a reform process, and the more that they have 'invested' in it, the less likely they are to resist future potentially controversial proposals. Thus, the programme of change is entrenched before powerful actors become aware that it may be in their interest to resist. Crucial support is best elicited before too many details of the initiative have been determined or released.

Flynn (1992) provides the introduction of the *Resource Management Initiative* (RMI) within hospitals as one example of a 'Trojan Horse' approach to health care reform. In this instance, consultants complained to the Health Minister that they felt that they had effectively been 'duped' into accepting RMI without understanding that this would lead to the formation of self-governing hospitals (NHS Trusts). The reform proceeded nevertheless, because by the time that consultants became aware of the ultimate objective of the changes, they were no longer in an effective position to offer resistance.

The creation of PCGs raises the question of whether this was another such 'Trojan Horse' policy, particularly the high level of initial ambiguity and the structured evolution of PCGs over time to Primary Care Trusts. Concurrence with a reform measure that initially seemed to empower the profession may have actually created the structures from which GPs will find any subsequent resistance more difficult.

6.3.2 Professional co-operation is important for policy implementation beyond simply preventing resistance

I have proposed that health care reform is often described as a process of ‘bureaucratisation’, and that this has been deemed to challenge professionals and professionalism alike. Policy makers may do well to take care, therefore, to present reform as somehow serving the professional project, in order to potentially incorporate doctors (Ham and Hunter, 1988).

At the same time, managers are often presented as actively engaging with the bureaucratisation processes, seemingly to strengthen their own power.

However, there is an alternate thesis whereby managers are seen as having little choice but to implement such policies (Griffiths and Hughes, 1999). From this perspective, local managers are portrayed as little more than the ‘messengers’ of central initiatives, rather than the instigators of change in pursuit of their own agendas. Indeed, managers’ awareness of the persuasive nature and cultural authority of professional and altruistic accounts of ‘caring for patients’ may limit their implementation of centralised bureaucratic measures.

In Griffiths and Hughes’ account, managers seek legitimacy by emphasising the extent to which their role is to simply apply the rules as determined by the government. This may be a valuable way of building a defence against charges of lay intrusion into the care domain on the part of medical professionals, as well as to the strength of public opinion over matters relating to health and health care.

6.4 GPs seek to create and maintain consensus

6.4.1 Professional reliance on state sponsorship

It may be that rather than having to 'drag' professionals into co-operation with reform initiatives, they join quite willingly because they recognise that such involvement is a potential means by which to strengthen their professional claim. Faced with an increasingly 'bureaucratised' world, GPs may welcome an opportunity to influence reform measures as an alternative to witnessing the processes of 'deprofessionalisation' (Haug, 1973), or even 'proletarianisation' (McKinlay and Arches, 1985) that are often predicted within sociological accounts.

Effective claims of professional status and privilege rely heavily on state 'sponsorship'. The state is the provider of the 'license' upon which professionals' authority to practice is based. Many professionals have seemingly embraced the idea of working within bureaucratic organisations in order to retain (an albeit redefined) state sponsorship, rather than facing a process of deprofessionalisation. Fielding and Portwood (1980) therefore maintain that professionalisation and bureaucratisation are interdependent processes within many welfare state systems, and that both have served beneficial to both the state and the professions.

6.4.2 Increasing structural interdependence requires co-operation

The newly forming PCGs incorporated complex accountability structures that were challenging for the established roles of both clinicians and managers. The power of different groups in the emerging structures had not yet been determined, and uncertainty was particularly apparent in relation to the continuing role of Health Authority managerial staff. Local interaction within the transitional period can be at least partially understood as resulting from managerial attempts to define and defend continued valid and influential roles. One Health Authority mid-level manager who was interviewed acknowledged these impending changes.

Health Authority PCG Implementation Officer - "I think that the Health Authority are sort of having to change their thinking and having to be a support mechanism for PCGs, rather than the governing body."

(Interview data)

Health Authority managers' co-operation can be interpreted as an effort to establish a new role as 'supporters' of the PCGs. Managers' precarious position meant that they could little afford to undermine the power of the newly forming organisations. During this transition period, Health Authority managers were working to position themselves in relation to the PCGs, but the structures were not yet in place to allow them to abandon their present roles. Managers were, therefore, facing some difficulty whereby their current positions were peripheral to the new structures, and their accounts of the change process tended to emphasise the centrality of their work to both the Health Authority and

the new PCG structures. These accounts also served to strengthen bonds between the Health Authority and PCGs.

The augmentation of the bonds between Health Authorities and PCGs was not simply the result of work being done by managers. As I have discussed in the previous two chapters, *The New NHS* confounded existing relationships through its simultaneous prioritisation of 'devolved decision making' and 'strengthened accountability structures'. One example of such complexity was the retention of Level One and Level Two PCGs as 'subcommittees' of the Health Authority under the overarching control of the Health Authority Board maintained overarching responsibility and control⁹⁹. 'Subcommittee status' implied restrictions, against which one might suppose that PCGs would necessarily struggle. Indeed, during the early preparation period, both local managers and GPs voiced resentment over such measures.

Implementation Officer – "There is a feeling from PCGs generally, not just mine, that the Health Authority is trying to be too controlling of PCGs. I think that that is partly true – but then again they have to because they are subcommittees of the Health Authority and therefore they don't necessarily want maverick organisations running off and doing completely their own thing."

(Interview data)

⁹⁹Progress to Levels Three and Four was dependent on agreement between the Health Authority and the PCG members that such movement was appropriate.

With time and further analysis, however, it became clear that the active incorporation of 'restricted' subcommittee status by PCG members frequently served members' own agendas. In such cases, it was usual for subcommittee status to have been incorporated into the effective working of PCGs, rather than being formulated as something to be actively fought against.

The significance of subcommittee status was raised several times by the GPs who were, or who became, PCG board members. GPs claimed that managers used the subcommittee status as a means of maintaining control over PCGs. The GPs themselves, however, were also able to use their status as members of a 'subcommittee' to lessen their perceived responsibility for potentially unpopular or difficult resource allocation decisions.

Furthermore, with the transfer of responsibility for rationing decisions from central government to local professionals incorporated with the devolution of budget, clinicians may have sought to emphasise their restrictions in terms of resource allocation, rather than balking at any limitations to their control. The extent to which 'subcommittee' status might actually impede the decisions of the PCGs did not, however, become clear during the fieldwork period.

Health Authority managers predicted only a limited transfer of authority to PCGs during the first year. Managers also tended to conceptualise themselves as determining the pace with which responsibility and power were to be shifted, rather than such changes being in the hands of professional or the PCGs. These predictions were set within descriptions of PCGs as struggling with their newly acquired workload and responsibilities. During a

period when many commentators were posing questions as to what the continued role of the Health Authority might possibly be, managers seemed to find it potentially valuable to construct accounts in which the managerial realm was presented as so firmly in control over both the pace and direction of change. The following comments made by a Health Authority manager illustrate their portrayals of their control over the pace, direction and extent of change.

Health Authority Manager - "We wouldn't allow them to have access to something that we wouldn't give to everybody (meaning the other PCGs). Not at least until the first year is out of the way. Because we have to have a gauge of what they can, or think that they can do....."

We decide what we want to hand down, because we have to be convinced that they are ready to take certain, and we don't want to disenfranchise the Trusts as well – to put them at risk."

(Interview data)

PCGs posed a significant challenge to the legitimacy of Health Authority managers in the realm of decision making. However, if managers could successfully conceptualise PCGs as inexperienced and overburdened, then they might be able to carve a niche for themselves as essential support mechanisms during the transitional period.

What is more, the complex and interrelated accountability structures served to ensure continued managerial co-operation with the new structures. As long as the Health

Authority remained accountable for the actions and decisions that the PCGs took, managers were unlikely to willingly devolve decision making to PCG boards completely. The PCG boards would struggle to wrest control over the pace of the devolution of control.

As mentioned previously, PCG board members were sometimes able to use the PCGs' status as subcommittees as a means by which to relinquish responsibility for some more difficult resource allocation decisions. The members of PCGs did not, however, produce accounts in which the Health Authority controlled the pace and direction of change. Neither did they present themselves as either unready or unwilling to take on additional responsibilities. Any resistance was more readily attributed to professional scepticism, or caution, in relation to central measures, or as an inevitable element of a gradual transfer of authority.

It became apparent that PCGs' status as both autonomous organisations and subcommittees of the Health Authority created tensions between local actors. In interviews, PCG GPs expressed frustration over uncertainty as to whether either the Health Authority or PCGs were ultimately in control over local decision making.

Commissioning GP – "PCG boards see their role as being more bottom up – looking at what the community needs are and what they issues are locally and feeding those back into the system. And there is a feeling that the Health Authority sees it as another body to consult on things that are being done centrally. The two don't always tally."

(Interview data)

The relative power of the different structures was also called into question within meetings. The issue of control over local decision making became particularly acute once target setting and the identification of local health care needs and priorities¹⁰⁰ became agenda items. In such instances, both GPs and managers tended to call upon distinct knowledge bases to assert their own authority. The following example comes from a discussion at a Programme of Care meeting¹⁰¹, and is one instance where a GP challenged the priorities being suggested by a Health Authority manager. In so doing, the GP questioned the continuing authority of the Health Authority to make such decisions, and reiterated the importance of GP support for such measures.

GP – “Where do these two subgroups – skin cancer and chlamydial infection – come from?”

Public Health Manager – “It was a practical decision. For example, skin cancer is something that we can actually do something about.”

GP – “I am asking because they are obviously relevant to many groups and we would all hope to be helpful. But, be aware that once PCGs are chosen they won’t be prepared to accept these being imposed upon them. They are just as much theirs as they are the Health Authority’s. We need to be careful how we approach this.”

(Observational data)

¹⁰⁰ As discussed in Chapters 4 and 5.

The New NHS created contradictions in relation to PCGs as both Health Authority subcommittees, and autonomous organisations. Difficulties became apparent soon after the release of the White Paper, and amendments were quickly instigated¹⁰². The determination of ultimate local control, however, remained a potential tinderbox. The status of PCGs was left quite precarious, with the seeming result that Health Authority managers were able to wrest greater control when they felt it was necessary. The perceived insecurity of the Health Authority in relation to their long term role alongside the new PCGs, as well as the accountability structure, seem to have encouraged managers to act to limit transferring power to the PCGs.

One might predict that this would lead to overt conflict between the newly forming organisations (who had been promised greater control by the government), and the existing superstructure that was averse to such devolution. By and large, my data do not support this hypothesis. I suggest that the members of the PCGs were willing to accept a slow pace of power devolution when it occurred alongside an equally slow engagement with accountability for difficult decisions. Through such an arrangement, confrontation was avoided; the slow pace of change, to a certain extent, seemed to suit both the Health Authority and the newly forming PCGs.

¹⁰¹ Health Authority and GP collaborative commissioning structure that preceded PCGs

¹⁰² One such amendment was that it would no longer be necessary for Health Authority staff to sit in the majority on all Health Authority committees. Nurses, doctors or lay people might now assume the majority on such structures.

6.5 How did local actors work to create and maintain consensus?

I wish to now explore the processes by which local managers and GPs worked to build co-operation and consensus. These data identify several instances in which local consensus was established and maintained. An analysis of the process by which this occurred is potentially valuable for a better understanding of both policy implementation, and professional/managerial relations.

6.5.1 The use of official policy to create a communal framework

Establishing 'common-ground' between key actors is important for successful collaboration. Official policy documents may serve as valuable tools for such a process - they can be influential hegemonic devices. Such documents can act as a means through which actors establish a common language and framework of action that will shape what is deemed possible.

Meyer and Rowan (1977) suggest that organisations often seek to gain legitimacy by demonstrating compliance with societal ideologies. Organisations can gain strength by adopting societal values that are difficult to refute. If policy makers incorporate societal ideologies into their initiatives such that they become organisational myths, then the organisation may benefit from being seen to hold those collective values. In the case of the 1997 reform, the ideas of 'clinical effectiveness', 'accountability', 'local sensitivity', 'patient-centred care', 'collaborative working' and 'quality' are all examples of

commonly-held notions of good health care. Policy makers' ability to frame organisational changes in relation to these ideas thus helped to disable criticism.

The official goal/s of an organisation are of limited use in any attempt to understand members' 'real' goals (Silverman, 1970). Official goals are more appropriately conceptualised as resources from which members draw to both to legitimise actions, and stimulate a consensus. Official organisational goals act more as post hoc reference points, than as determinants of action (Scott, 1987). Actors within a formal organisation use its 'rules and charters' to shape accounts of their actions (Strong and Dingwall, 1983; 98). Given this, we might expect both managers and GPs to work to incorporate the rhetoric of *The New NHS* into justifications for their pursuits of existing goals within the new structures.

The ability to demonstrate acknowledgement of, and adherence to, environmental expectations is an important part of gaining and maintaining legitimacy (Mohr, 1992). This may be done by linking organisational output, goals and methods to ones that have established local legitimacy. Health Authority managers' attempts to demonstrate commitment to 'local sensitivity' and 'local consultation' emerged as one example of the incorporation of legitimate ideas into action plans. *The New NHS* officially prioritised involving the public in the formation of Primary Care Groups by stating that, "*Openness and public involvement will be key features of the new NHS*" (p. 15). Health Authority managers were further able to demonstrate compliance by inviting people to "*put*

forward their ideas of the possible configuration for the City.” (Interview with Health Authority Manager).

It was not, however, evident that the Health Authority took any further measures to operationalise such ideas through their plans for PCGs. Configuration consultation yielded a variety of responses and possible models from local actors. Nevertheless, the only ideas to apparently receive ‘serious’ consideration were those concurring with the initial Health Authority proposal of following local authority boundaries (see later section on ‘Selective Facilitation’). All other proposals were defined as ‘unusual’, and subsequently discredited. The consultation process seemed primarily aimed at legitimising the Health Authority’s chosen model of configuration, rather than facilitating meaningful public contributions. It was important for the Health Authority to demonstrate that their decision was based upon a process of ‘local consultation’ as outlined in the policy document.

As well as incorporating official policy goals and targets, it is also useful for a member of an organisation to display adherence to collective norms. Norms act as cognitive guidance systems, and as such are used in the creation of ‘legitimising accounts’ within organisations (Garfinkel, in DiMaggio and Powell:1991). Furthermore, norms can be employed flexibly and retrospectively by actors to demonstrate that their behaviour is reasonable. For instance, during the Conservative reforms of the early 1990s, the terms ‘the market’ and ‘contracting’ came to reflect processes in which historic administrative budgets were recast within new language and rituals; new terms were adopted in order to

legitimise existing practice. (Light, 1999c: p. 28). In the 1997 reforms, 'local sensitivity' and 'stakeholder consultation' were similarly used as rhetorical devices.

In instances where local action did not explicitly reflect the ideological framework, actors often constructed explanatory accounts through which discretions were justified. For instance, the Health Authority Chief Executive acknowledged the limited extent to which the local structures have actually shaped the formation of the PCGs. He referred to the official policy rhetoric of local empowerment, but also emphasised the pervasive nature of central guidance as a mitigating factor. He presented local consultation as a genuine process in line with the reform measures, but claimed that the effectiveness of such measures was limited due to central guidance and control.

Health Authority Chief Executive – "In some ways I think that the national guidance has probably had more impact than say the fundholding guidance because we simply haven't been able to, the guidance hasn't permitted us to carry on as I think that we would have liked in Casterdale....

We have often examined whether we should transform ourselves into a locality based organisation¹⁰³ and we have always decided, 'No' because it doesn't fit in Casterdale.

But this national guidance has actually forced us to do that, and we have done it."

(Interview data)

¹⁰³ Increased localised micro management rather than centralised control with the Health Authority.

Why, if central guidance was so prescriptive, was an elaborate process of local consultation necessary? The process itself would appear to serve more as a justification process for the decisions taken, rather than a way to determine the eventual outcomes. Morgan (1990) presents an image of organisations as being primarily made up of action programmes in which change occurs on a regular and routine basis with little reflection as to its relevance. Problems and questions are retrospectively constructed in order to justify an action already taken. Rationality is a process through which to legitimise action in an organisation, rather than to assert the basis upon which such action will occur.

In the present setting, managers were able to use local consultation as a means of legitimising the implementation of both centrally formulated reforms, and the local managerial interpretations of such reforms, in preference to other professionally supported models.

6.5.2 The identification of a common enemy

Co-operation between GPs and managers within Casterdale was sometimes formulated in relation to secondary care doctors and other members of NHS Trusts. Such individuals could be conceptualised as ‘outsiders’, and problematic to the objectives and purposes of the reforms. A feeling of ‘them’ and ‘us’ developed quite rapidly between PCGs and hospitals, which was fostered by both the GPs and managers. The growing division was particularly evident in discussions of prescribing costs and amalgamated budgets.

Although overt conflict between managers and GPs was relatively rare within the

commissioning and PCG meetings observed, descriptions and discussions of conflict with secondary care representatives were quite commonplace.

Both managers and GPs seemed to use the identification of a 'common enemy' to facilitate consensus building within commissioning structures, and as part of the preparation process for PCGs. One GP who was interviewed described GPs and Health Authority managers as working 'harmoniously' together, and conceptualised the Trusts posing problems. A second GP based his claim for greater control over resources on a perceived necessity to wrest control from secondary to primary care.

GP – "The programme teams again, the decisions tend to be by consensus. They don't tend to have that many disagreements. The four GPs involved in the programme team seem to work very well with the Health Authority colleagues. They tend to deal with issues where there are problems with the hospital trusts. So, in that sense, not so much debate goes on. Although in some areas there are difficult decisions to be made. Certainly we haven't had anything in the programme team where there has been disagreement."

(Interview data)

(Interview with a PCG Chair)

GP – "We must produce a shift from secondary care domination to primary care provision. Now, I don't think that we will be allowed to do that until we control money."

(Interview data)

It is not possible to determine from the data available whether the Health Authority's alliance with the PCGs was stronger than that with the Trusts. It did not appear, however, as if the Health Authority expended much effort to contain the emerging divisions between PCGs and the Trusts that were based upon suspicion, mistrust and a perception of conflicting interests. There may have been utility for the Health Authority in fostering a perception of the Trusts as PCGs' natural 'opponents' in achieving the reform objectives. This may have served as an effective distraction from the formation of possible opposition to the Health Authority.

6.5.3 'Talking past' one another

As already outlined, open confrontation (particularly between managers and GPs) both within commissioning meetings, and during the preparation for PCGs, was quite rare. This is not to suggest, however, that managers and GPs were necessarily collaborating towards commonly held goals. The interaction observed rather suggests that different groups had developed techniques through which they could pursue their own agendas without facing too much overt confrontation. Often, it appeared that managers and GPs were talking different languages in relation to the reforms – and certainly focusing on different aspects of the proposed changes. The actors, however, seldom reacted negatively to this 'Tower of Babel' scenario. Instead, they continued to 'talk past' one another, and to tolerate these seeming 'miscommunications'. Furthermore, the incorporation of contrasting definitions, applications and foci served to facilitate the continued expression of numerous agendas and perspectives. Thus, 'talking past one

another' allowed actors to avoid instigating confrontation while continuing to air competing perspectives.

Deal and Kennedy (1988) propose that distinct cultures commonly develop in different parts of an organisation, and that this may impede organisational communication . My data, however, include several instances where key ideas or terms were applied differently, but where such differences did not seem to hinder communication or co-operation. Rather, they seemed to have facilitated it. 'The reduction of inequality' was one such example of participants' application and tolerance of different working definitions¹⁰⁴.

The notion of 'equality' runs throughout the White Paper, and was identified locally as a key reform objective. One PCG Chair noted, however, that the meaning behind the official objective of eradicating inequalities was not well defined, "*Let's get rid of inequalities*" – *a bit of a vague term, that.*' (Interview data). The complexity embroiled in defining 'equality' may be one reason that policy makers chose to minimise the detail provided within the policy document – although the *ideology* of equality runs strongly throughout its rhetoric. This in-built imprecision as to what precisely is meant and intended by the stated aim of reducing inequalities provides appropriate conditions for numerous different local applications to be made. Such different interpretations seemed to serve the purposes of various interest groups.

Heritage (1984: 141) states that descriptions are used to make available, maintain, transform or otherwise manage concerted social activities. In implementing *The New NHS*, actors could legitimately focus upon inequalities in resource allocation, inequality of available services, inequality of care given, inequality of health outcomes, or even inequality of life chances – all within the bounds of the policy. It makes sense that different definitions of terms would be applied depending on both the context and the actors involved. My task is to consider which definitions were applied, and to contemplate as to the purpose of each application.

In one instance, a GP who had been elected as Chair of a ‘deprived’ inner-city PCG, gave the following description of equality.

PCG Chair – “If you have got an area that has got the most inequalities in it and inequities – in all of the determinants of health – housing, unemployment, poor education, poor leisure facilities, over crowding – then the likelihood is that the opportunities for doing something about it now are better than they have ever been because there are funding streams.”

(Interview data)

This GP presented an image of equality based on the reallocation of resources in favour of those deemed to be most in need. Such an all-inclusive interpretation, as relating to the improvement of a sense of overall well-being, would necessitate greater resources being

¹⁰⁴ ‘Accountability’, ‘collegial working’ and ‘clinical governance’ are further examples for which divergent

directed to his PCG. This interpretation of 'reducing inequalities' can therefore be seen as quite purposive. If such a perspective were to be adopted, his PCG would benefit financially. Without additional funds, however, such equality would be sought through redistribution, and therefore, more money for this PCG would necessitate allocating less to another. One Health Authority public health consultant predicted that the funding another of the PCGs was likely to face challenges in the near future.

Public Health Consultant - "PCG X is going to face some problems actually because it has been very well supported in the past."

(Interview data)

Not surprisingly, therefore, GPs from relatively affluent areas put forward quite different models of equality. Their accounts tended to prioritise equality *within* PCGs, rather than between them. The following extract is from an interview with the GP Chair of the most affluent PCG. He frames the reduction of inequalities with reference only to the population of his particular PCG. He also focuses on healthcare, rather than generalised well-being. Reducing inequalities in healthcare provision and focusing on the 'local population' provides a 'legitimate' interpretation of policy without jeopardising the resource allocation to what may otherwise be considered an 'over resourced' PCG.

PCG Chair – "That seems to be the thing that is in the papers - so commissioning secondary care is very important. Though they seem to think that it is less important and

definitions and applications were successfully employed.

can be done centrally. However, locally, the sorts of things that we are supposed to concentrate on are areas of deprivation where the healthcare is of a lower standard than elsewhere. Getting good information from public health and the centre and concentrate on those areas and concentrate on the sort of areas like smoking in teenage girls, the incidence of heart disease, earlier diagnosis and treatment of cancer, accidents in the home, mental health in the community and a couple of those areas are also sort of national priorities and improve those in the patch that we are responsible for. That would be our prime aim as a primary care group – concentrating on the health that is provided in the community, rather than the health that that is provided in the secondary care – in the hospitals.”

(Interview data)

The application of ‘local communities’ is another example whereby actors called upon distinct interpretations of policy rhetoric to promote various agendas. *The New NHS* stated that PCGs would be based on ‘local communities’, without specifying what was meant by ‘local community’. Many GPs expressed strong opinions as to with whom they wished to amalgamate, and these were often reflected in (and perhaps served by) GPs’ interpretation of ‘local community’. The Chief Executive of the Local Medical Committee described GPs’ referral to official policy rhetoric as tactical.

Chief Executive of the Local Medical Committee - “We knew that particularly the rural GPs, fundholding GPs, are not happy to be bound because they were very keen on

‘natural communities’, and what they meant by natural communities was, ‘like-minded GPs’.”

(Interview data)

The GPs were also critical of the Health Authority’s definition of ‘local communities’. They expressed displeasure with managers’ interpretation of ‘local communities’ as meaning ‘co-terminosity with local authority boundaries’, rather than relating to either local clinicians or existing communities.

The issue of equality and resource reallocation created divisions between the PCGs. This was a source of considerable conflict at collaborative commissioning meetings during the shadow period, as well as once PCGs had ‘gone live (see ‘negative cases’ in Section 6.6). The issue of whether equality needed to be sought across PCGs, or simply within them, was a major area of discrepancy that contributed to direct confrontation between GPs within commissioning meetings¹⁰⁵.

PCG Chair – “It is a geographical entity that in my opinion doesn’t really have social coherence. It doesn’t even have coherence in social services terms. They rabbit on about PCGs being ‘co-terminus’, what a horrid word, with district boundaries, but part of our PCG is part of another district... ..So it is a problem, and I don’t think it is a coherent community.”

(Interview data)

¹⁰⁵ See section on ‘negative cases’.

Discrepancies between applications of terms are not unique to this setting. Light (1999c) notes, for example, that the term “efficiency” is often used in confusing and contradictory ways. Furthermore, Hughes and Griffiths’ (1999) recent research around NHS Trust contract setting processes also identifies that managers and doctors often hold different interpretations of key terms concurrently. Such differences can be accepted and incorporated into the negotiation process. Thus, there are times when distinct interpretations of central terms may actually serve various interests.

In Casterdale, different applications of the key terms were used to promote separate views. Most actors seemed keen to avoid a situation whereby any forced resolution may have led to the abandonment of local co-operation. The existence and accommodation of different interpretations of key terms such as ‘inequality’ or ‘local community’ seemed to facilitate continued collaboration between parties with quite different perspectives. Different groups were able to simultaneously pursue separate (and often quite disparate) agendas.

6.5.4 ‘Fudging’ issues and incorporating imprecise definitions

Observational data from the meetings often revealed work on the part of both GPs and Health Authority managers to avoid engagement with certain potentially problematic issues. Members’ practice of ‘ignoring’ particular references and steering discussion towards less controversial ground seemed to contribute to circumstances in which collaboration would not be unduly damaged.

Such ‘fudging’ on the part of the GP leadership was evident from the initial TCG meeting. During this meeting, one of the GPs (from the floor) asked the TCG board members,

GP - “If the TCG becomes lots of smaller PCGs, will they be given freedom?¹⁰⁶”

The Chair essentially ignored the question, and instead stated,

TCG Chair - “The TCG may well become a single PCG” He went on then to caution that, *“I am not aware of any funds being made available to prepare for PCGs.”*

Other board members supported the Chair’s comments by saying that as the government was looking to save money on administration they were unlikely to put additional money into this area. They ignored the potentially challenging question by steering discussion towards the problems associated with the scenario outlined in the question. Discussion was then moved to a different topic.

Later data suggest that the Chair’s response (as well as the comments from the other Board members) was based largely on an assumption, rather than any accurate ‘insider information’. The transformation of the TCG into a single PCG did not receive either government or Health Authority support. In this particular meeting, however, the Chair was able to avoid addressing the question of whether the PCGs would be given freedom from the collaborative commissioning mechanism. This issue was, however, still being struggled over some fifteen months later.

¹⁰⁶ From the collaborative commissioning structure.

These data serve not only as examples of instances where actors clearly held different interpretations of key ideas, but also where they accommodated a level of imprecision around terms. Heritage (1984) describes definitions as being continual compromises between generality and specificity. From his perspective, language is 'indexical', and its application is based upon practical necessity. Depending on one's purposes, there is an optimal level of specificity for the terms that one uses. Although one might assume that effective working would benefit from all relevant actors are applying the same, specified definitions, there is evidence to suggest that there are instances in which the coexistence of different interpretations of key terms and ideas serves the purposes of various individuals and interest groups. The present data demonstrate that precise definitions (either distinct or shared) are not always sought at all; sometimes 'vague' definitions facilitate collaboration.

'Clinical governance' was one aspect of the reform rhetoric for which actors never seemed to seek a precise definition. The idea of 'clinical governance', in its most abstract form, went largely unchallenged. Clinical governance was engaged with in ways that essentially left its 'essence' unexamined. It was discussed in several of the meetings as an abstract concept, but without engaging any details of what the introduction of this concept might mean for daily routine or larger structures. Meyer and Rowan (1977) propose that keeping goals ambiguous allows one to constantly strive towards them without fearing the consequences of possible failure. Retaining a certain level of ambiguity around an idea avoids having to deal with problematic details, and the

potential resistance of those who might be affected. It also allows thinking to be framed in relation to a commonly accepted notion without promoting any actual change.

The Health Authority avoided providing any precise definition of ‘clinical governance’, and thus GPs were denied the necessary details upon which to mount any effective objection. As the abstract ideas of clinical governance are key to notions of professional accountability, GPs might find objecting to theoretical proposals difficult to justify.

Detailed implementation plans may, however, have offered more opportunities for ‘defensible’ resistance.

On the other hand, avoiding engaging in a detailed discussion of clinical governance may have also served GPs. Clinical governance is often framed as potentially challenging to making a successful professional claim; it is encompassed by the idea of bureaucratisation. The imprecision around the term may have allowed GPs to delay the implementation of any practical changes.

The imprecision of the application of ‘clinical governance’ was raised in interviews with both managers and GPs.

PCG Chair - “Clinical governance is something that is going to be extremely difficult because defining it even is difficult. You look at a definition and it takes up half a side of A4 because people try to make it all embracing. If it is to do with standards of excellency then I can go along with that – I think that most doctors would feel comfortable with that.

But how you actually achieve it – carrots and sticks comes to mind, and I really don't know."

(Interview data)

Acting Director of Commissioning – "What clinical governance will turn out to be in the end is anybody's guess."

(Interview data)

Moreover, the Chief Executive of the Local Medical Committee referred to the lack of clarity in relation to clinical governance as relatively unproblematic. He described GPs who were deciding to take on managerial PCG board roles as seeming comfortable with the level of imprecision in relation to this topic. He predicted, however, that further clarifications would simply serve to alienate sections of the general GP population.

Local Medical Committee Chief Executive – " They are saying, 'We are going to take this slow and steady. Clinical governance is a very tricky issue. We have got enough problems getting this established – we don't want to start antagonising our colleagues from day one. We want to do this slowly."

(Interview data)

The idea of clinical governance was generally adopted as a 'good thing' in Casterdale; by the end of the period of fieldwork all of the PCGs had elected or appointed a 'clinical governance lead'. Thus, the PCGs were at least paying 'lip service' to the idea that

formalised clinical governance should be at the heart of the reformed NHS . The PCG GPs presented the retention of professional control over clinical governance as a strength, and tended to construct their accounts around this. Operational details, however, potentially posed more challenges, and were therefore generally either largely forgotten or avoided.

Beyond the provision of specific definitions for particular terms, Health Authority managers also appeared reluctant to provide details relating to the overall agenda of the reform process. The data never identify one commonly held reform agenda around which participants could unite. Actors seemed to avoid identifying a detailed target or agenda, and instead made numerous references to the policy rhetoric.

The Health Authority's Acting Director of Commissioning¹⁰⁷ commented on the lack of a precise reform agenda. He suggested that GPs' decision about whether to become more actively involved in PCGs was likely to have been influenced by the low level of detail provided.

Acting Director of Commissioning - "What I think is a bit, I don't know whether it is hoodwinking or not, a lot of GPs think that commissioning is the main agenda. Whereas I think the Department of Health thinks that the provision of primary and community care services is the primary agenda."

107 The Director of Commissioning took early retirement around this time. Speculation was made about possible connections to the PCG initiatives – but no conclusive data was gathered in either support or opposition to such ideas.

(Interview data)

Once general ideas (such as clinical governance, or a reform agenda) have gained acceptance, resistance against particular measures will prove more difficult. It may have therefore been policy makers' express intention to retain a level of imprecision (much like the 'Trojan Horse' policies already discussed). On the other hand, these 'vague' definitions might also reflect uncertainty on part of the policy makers. Policy makers may not have been hiding details from those involved, but rather, such details were not as yet determined.

Manning (1977) identified various ways in which actors can use a lack of clarity of terms to facilitate more harmonious interaction. He constructed a model of six different ways in which the term 'major violator' was used within narcotics (police) squads to accomplish different tasks. Three of the definitions were official terms that could be explained to outsiders. Whereas three others were locally formulated and operational, and were used by the officers within the work setting. The autonomy of individual participants and a lack of close supervision facilitated a shifting and unverifiable set of definitions (1977: 52).

Manning noted that *"If organizations are rule-negotiating contexts, then the shared and non-shared bases for negotiation are of operative importance."* (1977: 50). Operational definitions are effectively used to imply consensus; intractable ambiguity can be used to justify one's behaviour, and to associate it with official goals. Thus, the same term can be

used to indicate very different symbolic conceptions of goals, while also allowing actionable targets to shift – all within an mutually acceptable framework. Manning defined this phenomenon as ‘patterned ambiguities’; apparent consensus is maintained while allowing the uncertain and often fruitless job of (in this case) law enforcement to proceed (1977: 54). The interpretative contexts in which organisational rules are negotiated are, however, unlikely to be equally understood because shared understandings result from common experiences and identification with roles and concepts. The result is the accommodation of ‘shared misunderstandings’ that may provide a false or fictive sense of agreement. Furthermore, such ‘false’ agreement often serves the purposes of the more powerful organisational actors (Manning, 1977, p. 50).

In Casterdale, there were numerous examples of such shared misunderstandings, and the issue of whose purposes these served will be discussed more fully later in this chapter. There were, however, also instances when local actors challenged such ‘vague’ notions. The GPs, for instance, offered considerable resistance to co-operating with plans for PCGs without being provided with detailed information about changing conditions (particularly new roles and responsibilities, time commitments, remuneration and enhanced workload). In this instance, it seemed that the GPs did not judge the imprecision to be potentially advantageous.

GP – “I am not prepared to consider this (becoming a PCG chair) until I am clear about what ‘accountable’ means. Does it mean ‘to be a good boy’? Or, does it mean accountable in legal terms?”

(Observational data)

3.5.4.1 Summary

It did not always seem that the actors in Casterdale were actively seeking to reach commonly held, precise definitions and understandings of the concepts that were being introduced in the White Paper. Several of the key terms remained imprecise, or ‘fuzzy’ throughout the implementation period. This ambiguity seemed to be largely recognised and accepted by local actors. Sometimes the ‘fuzziness’ facilitated an avoidance of overt confrontation, and sometimes it seemed to be used as a ‘delaying’ tactic in relation to certain proposals. The acceptance of a level of imprecision only seemed to hold, however, when this was perceived to serve the interests of all of those involved. There were also instances where it served particular actors to reject the ambiguity, and to demand more details before acquiescing to proposed change.

6.5.5 The use of ‘selective facilitation’

Greatbach and Dingwall’s (1989) theory of selective facilitation has considerable salience in relation to the interaction taking place around the implementation of PCGs in Casterdale. Greatbach and Dingwall observed that divorce mediators were often able to maintain an image of neutrality while also significantly shaping the outcome of mediation sessions. Mediators steered discussion by selectively facilitating certain comments, and ignoring other less favoured options. Such tactics allowed them to encourage dialogue on topics that they felt to be appropriate, and to avoid engaging with issues less in line with

their ideas, while retaining a 'neutral' position. Only certain ideas are allowed to be discussed, and therefore, only certain outcomes are made possible.

Various Casterdale actors used similar techniques to pursue particular agendas without appearing to influence the eventual outcome or decision being made by the larger group. Several observations of decision-making processes both within the TCG and the newly forming PCGs suggest that selective facilitation played a role in the maintenance of a local consensus.

Selective facilitation was evident from the 'management style' of the TCG board members from the initial meeting. At this meeting, 'ordinary' GPs expressed dissatisfaction with many of the decisions taken on their behalf by the Project Board – particularly the decision to hold the prescribing incentive at the district level. The GPs questioned the authority of the TCG Forum and Board to make such decisions. One GP suggested that the matter be voted upon in the general meeting. A vote was subsequently conducted by a show of hands, and this result seemed fairly evenly split. The board, however, appeared to ignore the unfavourable outcome of this impromptu decision. The Chair did not take an official count, but instead declared that the decision (to deal with prescribing incentives at the district level) stood. The Chair commented (after the show of hands was conducted) that, *"The status of the show of hands was to inform the board rather than to take a decision."* By making such a statement, he seemed to be attempting to justify subsequently ignoring GPs' opposition.

I was sitting in the audience during this meeting, and the GPs around me engaged in conversations about their dissatisfaction with the way that their concerns over this issue had been handled. After the Chair announced that the decision taken by the board would stand, the GPs began to discuss what powers they might have to veto this decision. They did not, however, follow up their expressions of dissatisfaction with any action to reject the project. By the following week, all of the GPs present at the open meeting had confirmed their willingness to be a part of the TCG.

The TCG open meeting stands as one example whereby the feelings and opinions expressed by the group were successfully ‘overlooked’ by those in control. The Chair seemingly avoided engaging in more discussion of the possibility of ‘practice based’ incentive structures that were not in line with those being officially proposed. In so doing, his agenda was facilitated, and effective opposition was undermined.

There were other instances where the opportunity for members to ‘air’ opinions seemed to be employed in order to gain general assent and compliance, without those in power necessarily displaying much clear intention of incorporating expressed opinions into subsequent decisions. One such issue was the configuration of PCGs. The description of the consultation process given by one Health Authority manager certainly seems to support the idea that this process was seen as important for gaining professional compliance – regardless of whether expressed views were actually accommodated.

Health Authority Manager - "There has been a lot of talk about whether PCGs may be broken into smaller units for some things, particularly when they start looking at the provision of local services. That is not to say that they will do it, but it was an idea that was aired at a couple of the consultation meetings that people were quite interested in and it was a way of getting around this sort of 'We've got nothing in common with them, but you've put us in the same group' kind of thing."

(Interview data)

Presenting an appearance of accommodating different requests may have been sufficient to gain co-operation, particularly if participants were relatively unaware of the scope of organisational possibilities or probabilities.

Health Authority managers asserted their influence over that of the local GPs in various ways during this configuration consultation. The TCG GPs largely supported a configuration model built on the existing, and largely inclusive, Total Commissioning Group. This particular model of PCGs had, however, essentially been rejected by the Health Authority before the period of consultation began, but managers did not make this rejection overt. The option of a single PCG was instead retained in the official consultation documents and process, but only discussion on the preferred model was facilitated in meetings with GPs.

The comments made by one GP at a Forum meeting during the period of configuration consultation demonstrate some awareness of this tactic.

GP – “I don’t think that there has been an adequate discussion of the configuration issue to come to the conclusion that there is no consensus among GPs. There hasn’t been a discussion of all of the options. The Government is pushing for [the model with several PCGs]. The Health Authority Chief Executive stifled any discussion of a large PCG at the first meeting. There hasn’t been a discussion of having a big PCG – but we have assumed that there can’t be a big PCG.”

(Observational data)

The timing of this TCG Forum meeting coincided with a series of ‘negotiation’ meetings between the Health Authority and ‘local stakeholders’; several members were actually absent for the Forum meeting because they were attending the ‘stakeholder input’ meeting for their area. During the meeting, GPs’ described being uncertain as to whether the Health Authority had already taken the configuration decision, or whether they should actively campaign for their preferred option of a single PCG, based on the framework of the TCG. Even the Chair of the Forum, who usually had fairly good access to information, expressed concern.

TCG Chair discusses the PCG configuration meetings that have taken place so far.

TCG Chair – “They are giving mixed messages. The Health Authority are saying that they are being encouraged or told to keep PCGs between 70,000 and 120,000 patients. But, there has been another message given that if a robust case for a large PCG was put forward it would be considered. Three options had been considered:

- 1. The TCG would become a single PCG. This is no longer an option.*
 - 2. There would be a division for PCGs along borough lines but keeping the City boroughs together.*
 - 3. There would be a division along borough lines and the City be divided.”*
- (Observational data)*

Manning (1977) suggested that certain actors may benefit from others' uncertainty both by fabricating information, and by concealing information that they possess. In Casterdale, uncertainty seems to have contributed to the TCG Chair's decision to abandon the preferred option of a large PCG based on the structure of the TCG. The option of a single PCG based on the TCG structure was not, however, officially removed from the consultation process with the GPs. The Health Authority could therefore defend themselves against any allegation that they were prejudiced against this option. At the same time, this model would be difficult (if not impossible) to implement because it received little or no official support.

Later in the fieldwork process, a Health Authority manager reflected on the decision to include the 'single PCG' option within the consultation process.

Health Authority manager - “...and a third one was having the Total Commissioning Group as a PCG (sighs), which we had sort of discounted early on but there had been a lot of talk with ministers by some of our GPs, and we were advised that we needed to consider it right up until the end or else we could have been taken to judicial review for being prejudicial against it. So, on that advice we included that as an option in the

paper. What the paper did was for each option went through the pros and cons for it, and then looked at the level of support that it had. It was obviously easy to talk about the support for this one (the Health Authority model based on local boundaries) because this had been considered as a model itself. So, lots of people had responded.”

(Interview data)

.....

He presented the decision to include the “Single PCG” option throughout the configuration consultation as very strategic. Although the formation of a single PCG was theoretically possible, the lack of consultation in relation to this option meant that there was little evidence of any support. The option was therefore easily discounted. Health Authority managers controlled the existing organisational structures, and were therefore able to continue to maintain a position of ‘neutrality’ without ever fearing that GPs could effectively challenge their preferred structure of several PCGs. It also became apparent that powerful actors used selective facilitation with the seeming result of serving their own agendas, GPs even engaged in such measures with one another. One PCG Chair used selective facilitation to elicit GP support for his preferred agenda.

This GP called a PCG stakeholders’ meeting with the expressed intention of identifying local priorities. Those who attended were organised into small, profession-specific workgroups, supposedly with the aim of identifying pertinent local issues and appropriate PCG goals. I observed the GPs’ workgroup that was chaired by the PCG Chair. The group consisted of inner-city practice GPs, who over the course of the meeting identified several health care priorities around the issues related to urban life and disadvantaged

patient populations. They raised the issues of poor housing, cultural differences, teenage pregnancy, drug and substance abuse, violence and crime. The Chair, however, took a different perspective, and focused on the PCG's ability to communicate centralised data to the practice level, and their ability to incorporate such data in order to implement change. Other members of the group did not seem to particularly engage with this idea, and it was not discussed at any length. Still, when it came time to feed back the small-group discussions to the wider group, the Chair identified communication as the identified priority. He appeared to treat "stakeholder" consultation more as a rhetorical device than as a means of actually soliciting and incorporating members' views.

Manning's (1977) observation that organisational knowledge is not simply filed for general use, but is rather differentially available depending on one's power, is relevant to my consideration of 'selective facilitation' as a means of maintaining surface level agreement, and apparent neutrality. All of the instances of selective facilitation observed in Casterdale were instigated and controlled by those in official positions of power – be they managers or GPs. Selective facilitation served to 'smooth the waters' by disabling potentially problematic individuals from groups who were not in positions of control.

6.5.6 Minimizing communications with 'ordinary' PCG members

Opportunities for communication between 'ordinary' GPs within the same PCG, and between PCG Board members and 'ordinary' GPs were not as plentiful as one might have expected during such a period of organisational implementation. Rather than hindering the process, however, this lack of communication seemed to serve as another means of

avoiding potential conflict. The TCG and PCG GPs described minimising communication as one way of ‘making life easier’ for board members. They justified the low level of communication on the basis of seeking not to irritate ordinary members, and claimed that such members had no particular interest in either the changes that were occurring, or decisions being taken.

In the TCG, ‘ordinary’ members’ influence on decisions was largely dependent on their elected representatives passing on information. There was, however, at least one fairly dramatic instance in which board members decided *not* to inform GP members about an issue on the basis that it would be embarrassing to Forum members and it might lead to GP resistance towards the Forum’s preferred action.

The issue of getting informed consent from the GPs for the use of their practice data was raised at the June TCG Forum. A national prescribing body had indicated that the TCG needed explicit consent to use practice data, whereas the TCG had been assuming such consent from GPs’ agreement to join the project. TCG members described attaining such consent as an inconvenience for the TCG, and the TCG Chair was successful in convincing the prescribing body to change their position on this issue, and to accept the general sign up as implicit consent to the use of data. The discussion at the Forum concerned whether the TCG needed to inform the GPs that such a decision (to use their practice data for the purposes of determining appropriate prescribing levels) had been taken. The following extract is taken from my field notes.

GP 1 – “Do people think that the GPs would be happy with the TCG’s interpretation of the decision (that implicit consent to use data was implied in GPs’ signing up to the project)?”

A fairly lengthy discussion followed and the decision was taken not to say anything to GPs as it was likely just to stir up trouble and it would be easier to apologise afterwards if they found that they had done something wrong (the Chair put forward this position). It was decided that consent (to look at and use practice data) was a central part to joining the TCG.

GP 2 asked the Chair to write to the Chief Executive of the LMC and inform him of the situation as he was the most likely person to field any concerns.

(Observational data)

The TCG’s structure supported the practice of minimising communication both to and from Forum members. The Forum was based upon ‘constituencies’ of GPs who were represented by GP colleagues. Not all of these TCG representatives, however, lived or practised, in their constituency. Forum members did not necessarily know their constituents very well, and there was no formalised system of communication other than a ‘one-way’ newsletter¹⁰⁸. The lack of communication may not necessarily reflect any ‘failure’, but may have rather been a means by which to avoid delay and disagreements

¹⁰⁸ This ‘communication failure’ was later used to defend the decision to form several smaller PCGs rather than one large group based on the TCG.

where possible. One Forum member's¹⁰⁹ comments illustrate this minimalist attitude towards a consultation.

GP – “So, yes, there are a group of practices in my area, for whom I am their TCG representative. But we don’t actually have regular meetings. There is no structure in that sense – but I don’t think that any of the constituencies have anything of that sort. We (collectively as a TCG) have a regular newsletter that goes out that identifies me as being the person to contact – and in reality I have had one or two direct contacts since September (eight months) from people of the constituencies.”

(Interview data)

The GP justified this low level of communication by claiming that most GPs do not want to do this type of work; they are happy to leave it to others. By abdicating responsibility to their professional colleagues, however, these GPs are placing themselves in a disadvantaged position. They are likely to remain relatively unaware of what is being done on their behalf. The commissioning GPs were able to ‘speak for’ other GPs without actually consulting with them. As well as facilitating the decision making process, the lack of communication might also have served to prevent rivalry from other ‘ordinary’ GPs for these leadership positions. The lack of communication prevents ‘ordinary’ GPs from appreciating what the work involves. Members remain largely inexperienced, making effective leadership challenges difficult.

¹⁰⁹ Who later went on to become a PCG chair

One GP presented an account of other GPs as having minimal interest in augmented involvement in commissioning and PCG work. He claimed that the decisions being taken through these structures were of little significance to most GPs. Yet, this GP was interested enough in the work and the subsequent decisions being made to spend several hours a week working on commissioning and PCG business.

GP – “I don’t know that there is a great desire for practices not involved directly to be involved in anything. A lot of people are happy for those GPs who were elected to do the commissioning. There are one or two things that have come up – but it is very seldom that that has happened.”

(Interview data)

This pattern of non-consultation seems set to continue with the advent of PCGs. One of the PCGs held a ‘stakeholder’ meeting soon after the formation of PCGs, and the Chair expressed considerable pride about putting such a structure into place. This meeting revealed, however, that this would be the only arena for communication between the PCG ‘at large’ and the board members. Many important decisions would be taken without any consultation process.

PCG Chair – “The PCG board took the decision not to express interest in moving towards trust status. We need to know more about what that means first. We didn’t have time to consult you over this due to a very tight time constraint... .. We have taken a

decision at project board level to prioritise heart disease and strokes. Again, there was no time to consult you over this."

(Observational data)

Ordinary GPs and other 'stakeholders' were very restricted in their ability to put their 'needs' or priorities across, even in instances where this was formally accommodated. The Chair justified these exclusions as resulting from time constraints. There was no indication, however, that efforts were being made to put structures in place that would facilitate more active member input within the available timeframe. It seems, therefore, that even within this most 'inclusive' PCG, reporting decisions to stakeholders was prioritised over any meaningful inclusion of stakeholders in the decision-making process.

6.5.7 Focusing on extreme examples

The implementation period for PCGs was a time of considerable uncertainty and flux. Much of the discussion observed between participants in the commissioning meetings, and the accounts given in the interviews, dealt with 'what if?' issues. Predictions as to what might occur were frequent agenda items, and such predictions often seemed to be used to facilitate the planning process. When such 'what if?' questions were posed, extreme examples were regularly employed in response. People chose to call on either 'doomsday' scenarios or 'pipe dreams', rather than to present scenarios more in line with actual experiences. References to extreme examples seemed to be an innovative strategy employed by local actors.

6.5.7.1 Worst Case Scenarios

The following extracts are instances in which ‘worst case scenarios’ were provided in response to requests for predictions about PCGs. The provision of the worst possible outcomes enabled actors to avoid discussing the details of more likely scenarios. The following extract is taken from a commissioning meeting in which GPs discussed options with regards to the proposed structural changes.

GP 1 – “Should we as a group require the Chief Executive to assure us that GPs will need to be involved at the time of decision making?”

Chair – “They can say, ‘Sod off. You are a subcommittee and we will do what we want.’”

(Observational data)

The meetings that I observed, and the accounts that were given in interviews provided little support for the notion that such overt confrontation and assertion of authority on the part of the Health Authority was a likely scenario. The idea that a Health Authority representative would tell PCG representatives to, ‘Sod off’ did not reflect any interaction that I witnessed.

Another instance whereby an actor called upon the worst possible outcome was when the GPs in one PCG chose to frame the issue of increased ‘lay membership’ on PCG boards in relation to the possibility of having to sanction failing GP practices.

(Extract from a PCG Board meeting where the inclusion of a representative from the Community Health Council on the Board was being discussed.)

GP – “I wouldn’t be happy for them to be here in cases where we are dealing with failing practices. In such cases, the less people in the room the better.”

(Observational data)

Until this point, no case of a ‘failing practice’ had ever come before either the TCG Forum, or any PCG. The new structures had not even determined how such an issue might be dealt with. Yet, in this PCG meeting, the discussion about including a community health representative on the board was dominated by a very negative portrayal of the possibility that this would be prohibitive to possible future professional regulation. The possibility of other pros and cons were not discussed because the available time (and energy!) was spent in regards to this one seemingly peripheral issue.

Extreme negative examples were prevalent in meetings, as well as in interview accounts. GPs and managers avoided discussing details of future structures by focusing on extremely negative possible outcomes. In the following example, a Health Authority Public Health Consultant answers a question about possible Health Authority responses by constructing a fairly ridiculous hypothetical scenario.

KC – “Right, so what happens if the PCG makes a decision that the Health Authority doesn’t like?”

Health Authority Public Health Consultant – “Well, technically they (the Health Authority) can, I think, veto it. They still have a certain amount of residual powers.... You come to me and say that you want to spend ten million pounds on so and so and I know that you haven’t got ten million – I am going to veto it.”

(Interview data)

The extreme examples seemed to be called upon as mechanisms to unite members, or to ‘close ranks’. They also allowed members to avoid detailing with the ‘nitty gritty’ details of pertinent issues. By suggesting that the Health Authority could tell the PCGs to “sod off” the Public Health Consultant avoided discussing the actual state of the power relationship between these two organisations. A serious consideration of many such issues was undermined by focusing people’s attention on “extremes”.

6.5.7.2 Pipe Dreams

With the formation of PCGs, the collaborative commissioning meetings became an opportunity to raise difficult issues. One such issue was the approach that collaborative commissioning should take towards ‘reducing inequalities’. Each PCG had a different historic spending level, and the PCG collaborative commissioning meetings therefore often included discussions of whether amalgamated budgets (between PCGs) should follow historical spending patterns (which would advantage the traditionally well-resourced areas), or whether they might redistribute resources and services (which would benefit more ‘deprived’ areas)¹¹⁰.

¹¹⁰ See discussion earlier in the chapter.

Actors either chose to present such differences either as being a reflection of differing priorities (“Our PCG chooses to prioritise physiotherapy”), or as the result of pressure being put on resources from different levels of need of certain populations (“Our PCG has a population with higher mental health/physiotherapy needs”) The different perspectives are particularly stark within the following extract about mental health services resources.

GP 1 – “We are supposed to be commissioning collaboratively. We have looked at this in terms of equity and PCG X is over resourced.”

GP 2 (from PCG X) – “The HAZ (Health Action Zone) money will be invested to bring money around in relation to one particular issue. You need to see things from a historical basis. You need to replace like for like.”

(Observational data)

In this instance, actors presented different perspectives of the process of collaborative commissioning, and different applications of the idea of equality. The resolution of this difference seems central to establishing an effective commissioning programme. Yet, the GPs involved in the collaborative structure were able to avoid coming to any decision by raising the possibility of ‘levelling up’ spending to that of the best-resourced PCG.

GP 3 – “Could we do the sums to determine what it would cost us to bring everyone up to the standard of the best fundholding practice?”

GP 1 – “We have looked at it. As it is we are only able to provide just over ½ of what we think is necessary in terms of this service.

(Observational data)

Ongoing discussion had made it clear that the government was unlikely to make additional funds available to PCGs. GP3's position in relation to commissioning (he was an experienced, politically active member of the TCG) suggests that he was aware of this. It is difficult to see how his suggestion of 'levelling up' could have been intended as a serious practical suggestion. It seems more likely that this was utilised to prevent direct confrontation, or a possible impasse over the role to be played by collaborative commissioning and the reduction of inequalities. His approach served to protect the existence of collaborative commissioning and to preclude collegial confrontation – at least in the very short term. Eventually, such issues will surely have to be faced. When this occurs, the collaborative commissioning mechanism may well collapse.

Manning (1977) described official organisational goals as being 'yardsticks' by which members' conduct can be assessed. From this perspective, it is the existence of such goals, and not necessarily the attainment of them, that is most important. Perhaps 'pipe dreams' are being used as 'yardsticks, to shape how people conceptualise their work and guide what they might strive for.

6.5.8 Making use of a leadership void

During much of my fieldwork, there was a perceivable ‘void’ in GP leadership; it often seemed that everyone was waiting for PCGs to be instigated. Managers and GPs both recognised that PCG Chairs would be important future participants in decision-making processes, but these offices remained simply prospective for several months. In the meantime, Health Authority managers were able to fill the leadership ‘gap’; they could legitimise not seeking other, existing structures through which to consult GPs on important issues.

Managers sometimes called upon the LMC and the TCG for guidance during this period. These structures were, however, only assigned ‘proxy’ status for the as yet, non-existent PCGs. The LMC and TCG GPs had previously been relatively powerful individuals, but now they found themselves largely ‘cut out of the loop’. This seemed to empower managers to make decisions on behalf of future PCGs without having to engage with a detailed professional consultation process. In turn, the possibility of disagreement that such a process might engender was reduced. Considerable dissatisfaction and frustration with this scenario was expressed by (previously influential) GPs.

(Field notes from one of the last TCG forum meetings before the structure changed to the PCG collaborative commissioning mechanism)

Discussion occurred about the transfer to the PCG structure and the lack of information being given to GPs. The Chair expressed sadness that he hadn't been informed of the redundancy notice being given to the Health Authority manager who had been in charge of co-ordinating commissioning. The Chair said that he felt that the commissioning GPs

were being kept in the dark because the Health Authority is waiting for the election of the PCG Chairs. He said that the chairs will undoubtedly be influential people. The LMC was not being kept informed either.

Other board members responded by saying that this was indicative of the level of respect that the Health Authority had for GPs, when it suits them the Health Authority will keep GPs in the dark.

GP – “We’ve been fairly casual in Casterdale knowing that people in whom we have confidence are in place. I think that GPs would be very disappointed if they knew how these people are being treated.”

(Observational data)

Eventually, most of the GPs who had been involved in the TCG and the LMC took on the leadership positions within PCGs. Thus, Health Authority managers’ decision to ‘freeze out’ the existing professional representation and leadership on the basis that new influential personnel would emerge with the PCGs may be called into question in terms of its long-term efficacy. The GPs who had been ‘slighted’ during the transition period became officially influential again once PCGs were in place. The question then becomes - was the temporary control gained by the Health Authority worth the possible loss of ‘good will’ on the part of such GP ‘enthusiasts’?

6.6 When did consensus building and co-operation break down?

So far, I have focused upon the effort expended to create and maintain consensus and co-operation between actors at the local level. I have suggested several reasons why such co-operation (particularly between managers and doctors) was quite unexpected, and why consensus may have been sought in this particular instance. There was considerable evidence that actors employed different strategies to create consensus and to avoid confrontation. There were, however, also several instances in which compromise or consensus was either not possible, or not actively sought. Some such instances resulted in overt confrontation within meetings.

Conflict did not occur along one structural 'fault line', or within one particularly fragile organisational relationship. Rather, there was evidence of both opposition between GPs, and discord between GPs and management. There were also various issues within the reform process that seemed to induce confrontation. A consideration of such instances as 'negative cases' is both important in its own right, and may shed additional light on both how and why consensus tended to be attained.

6.6.1 Conflict Between GPs

In the weeks following the release of the White Paper, GPs expressed considerable hostility towards the reforms being proposed. GPs' resistance to additional involvement in managerial decisions was illustrated through the description given by one 'political' GP to his colleagues at a TCG meeting soon after the White Paper's release.

GP - "We are being sucked into the management of the Health Authority. We need to avoid this and stick to planning and vision etc."

(Observational data)

By the time that the elections for PCG board members took place, however, a sizeable group of GPs had shown themselves to be willing to take on the additional responsibilities being offered to them. Such willingness raised a potential challenge for the strength of the profession. GPs' involvement in managerial tasks created schisms, which were the basis for a more hierarchical structure than had previously existed.

The existence of an emerging hierarchy between 'ordinary' and 'insider' GPs was discussed more fully in Chapters 4 and 5 (in relation to decentralisation of control and clinical governance). Professional occupations have been seen to gain strength from their homogeneity and lack of internal stratification (Freidson, 1983), and the 1997 reforms appeared to challenge such a status quo. FitzGerald (1996) found similar evidence of internal professional divisions tending to develop alongside health care reform. GPs used emotive terms such as 'betrayal' and 'desertion' towards colleagues who took on positions as clinical managers. The PCG structure in Casterdale, however, seemed to limit the opportunity for such interchanges between 'insider' and 'ordinary' GPs such that such negative opinions tended not to be voiced.

6.6.2 Conflict Between PCGs

Beyond the tensions between individual professionals, there were also instances of ‘meso-level’ confrontations between the PCGs. I found the speed with which the new organisations (PCGs) formed identities and cohesive bonds quite surprising. As already discussed, *The New NHS* clearly stated that there would only be very limited additional funds, and that redistribution of funds would be the basis for PCG innovations. Such redistribution plans tended to create oppositional forces among GPs, and the resulting confrontation appeared most acute (at least at this time) between PCGs – seemingly augmented by the collaborative commissioning structure.

The objective of reducing inequalities seemed to be generally accepted by GPs who chose to become involved in the management of PCGs¹¹¹. Their definition of ‘equality’ and the interpretation of whether the focus should be between PCGs as well as within them, however, differed along PCG lines¹¹². Members of wealthier PCGs tended to define equality as internal to each PCG, while those from deprived areas had a more universal outlook. The resolution of this issue appeared to be crucial in relation to the continuation of a collaborative commissioning structure. The underlying differences were not, however, resolved during the fieldwork period.

6.6.3 Conflict Between Health Authority and GPs.

¹¹¹ See 6.5.3

¹¹² As discussed in Chapter 4.7

Areas of open hostility or ‘consensus breakdown’ also occasionally occurred at the interface between the Health Authority and GPs. Hostility was displayed, for example, over the availability of information for the use of the commissioning group/PCGs – particularly the production of referral information¹¹³. GPs claimed that when their objectives differed from those of the Health Authority, managers were able to prevent progress by limiting access to essential information. As such, the GPs were unable to commission effectively. Furthermore, because there was no evident accountability structure ‘downwards’ from the Health Authority, there was not necessarily anybody to address GPs’ concerns. The following extract from a commissioning meeting was typical of the dissatisfaction expressed by GPs regarding the treatment of agenda items not prioritised by Health Authority managers.

GP Chair – “We need to deal with this [use of referral information] directly with the Health Authority. We need to kick ass at the highest level.”

GP 2 – “This is clearly something that we see as a priority and they don’t....”

GP – “There is nobody’s desk for this to land on.”

(Observational data)

GPs frequently expressed frustration at commissioning meetings from which representatives of the Health Authority were usually absent. These ‘outbursts’ may, however, have served more as a means of ‘letting off steam’, or of constructing a

¹¹³ See Chapter 5

common enemy (the Health Authority), than reflecting any preparation for actual confrontation with local management. I did not observe very many instances of interaction between Health Authority management and PCGs, and I cannot therefore comment as to whether or not the 'threats' of confrontation produced in the GP dominated meetings were actually operationalised.

The level of GP dissatisfaction and frustration raises the question of the 'legitimacy' of the GPs' new role within managerial structures, particularly when the professional agenda does not match that of the Health Authority. There were not structures in place to allow GPs to effectively pursue their own objectives, and it was not clear from this research whether this scenario reflected a temporary 'hiccup' or a more permanent imbalance of power.

Conflict between the newly forming PCGs and the Health Authority seemed to result somewhat from centrally initiated pressure on the Health Authority to adhere to strict timescales in relation to many aspects of the reforms. The Health Improvement Programme (HIMP) and the Health Action Zones (HAZs) were both national programmes introduced alongside PCGs. These initiatives involved demanding targets and timescales for action that did not always sit easily with the structural changes brought about with the advent of PCGs. Health Authority managers also claimed that the involvement of PCG members in the planning and implementation stages of the HAZ and the HIMP was important because the changes would pertain to the new (not as yet formed) PCGs.

The managers therefore carried out a 'consultation process' in relation to the HIMP and the HAZ with the emerging PCG structures. They attended meetings of local clinicians (the TCG Forum, the Collaborative Commissioning Mechanism, and the newly forming PCGs) to explain what the HIMP and the HAZ entailed and what priorities had been set. On several occasions, these consultation meetings were settings for fairly overt confrontation between GPs and Health Authority managers. The following extract is from the September 1998 TCG Forum. It pertains to a Health Authority manager's presentation on the HIMP. The TCG GPs challenged many of the assertions made about the HIMP, specifically the targeting or prioritisation decision making procedure.

Health Authority Representative– "Do you think that we are off track with these targets?"

GP1 – "I have concern about skin cancer. I think that it has been chosen because it is easy rather than because it is important in comparison to the other cancers."

GP2 – " We have lost teenage pregnancy. I worry that it has been lost due to the difficulty meeting targets." (other GPs mutter agreements)

GP3 – "You have targeted something that many of us would consider trivial (skin cancer) and have left something out that we all see as very important."

Health Authority Representative – “I will feed this back.”

(Observational data)

While this interaction may not initially appear to have been particularly confrontational, both the tone of the interchange, and the directness of the challenges, differentiate it from ‘normal’ interaction within such meetings. GP3 employed the critical term ‘trivial’ to describe one of the priorities identified by the Health Authority . GP2 also boldly suggested that skin cancer had been prioritised not based upon need but upon the ease with which it might be achieved. Such comments were quite striking in comparison to the norm of polite interchange and subtle critiques that typified interaction within the setting.

Professional involvement in decision making and resource allocation in the very early stages of PCG formation seemed to be an area of considerable confrontation between the GPs and the Health Authority. There was some disparity between the Health Authority managers’ accounts and the action that I observed. Managers appeared to recognise significant ‘ownership’ issues in relation to PCG involvement in early decision-making, and expressed some willingness to involve PCGs in the preparatory decisions. Managers who were charged with incorporating PCGs into priority setting and other central initiatives anticipated having difficulty in achieving a level of professional involvement that was seen as being meaningful and effective.

Health Authority Manager – “The PCG chairs-elect, some of them know who they are going to be, they are itching, chomping at the bit to get in here and start and get involved and they think that the Health Authority are in a way going in too fast and doing too much without them being involved. So it is very difficult. We are trying to balance it by doing what we have to do to meet deadlines, but not trying to overstep the mark in determining what PCGs should be doing.”

(Interview data)

There was one PCG for whom relationships with the Health Authority were particularly strained. The PCG in question represented a relatively affluent and rural population, and had the highest concentration of ex-fundholders. The GPs maintained their reluctance to become involved in PCGs longer than in other areas, and they set up a structure whereby those who agreed to take on PCG board positions in the shadow period would all resign before the ‘going live’ date of April 1st. The Chair of this PCG actually resigned his post before this time.

The interaction between the Health Authority and members of this PCG was openly confrontational with some frequency. One illustration of such hostility was an interchange that occurred within an early PCG board meeting in which the Health Action Zone Co-ordinator (from the Health Authority) was outlining the decision about how to best allocate the small amount of additional resources allocated to this PCG through the HAZ initiative. Similar presentations had already been made to all of the other PCGs (all of whom were to receive larger sums of new money).

A tense altercation between local GPs and the HAZ Co-ordinator occurred after his presentation. His 'suggestions' about how additional resources might be spent met with hearty GP disagreement. The GPs asserted their working expertise – claiming a monopoly over knowing what was right and needed in the area. In turn, their 'locally informed knowledge' was swiftly dismissed by the Health Authority representative, and subsequently, communication effectively broke down.

Health Authority Representative (HA) – “Coronary heart disease and smoking and teenage pregnancy have already been correctly identified by you. There are also issues of homelessness, young single families, substance misuse and Asian mental health needs.”

GP – “Why have you identified this?” (Referring to Asian mental health needs and said in a confrontational tone)

HA – “It is a growing need.”

GP – “As a working GP this surprises me.”

HA – “The suicide rate for Asian women is a national issue. There is also the issue of domestic violence. Women will not come to you about this. There is also a very big issue around drugs and alcohol, but all of these things are very hidden.”

(Observational data)

In this interchange, both actors appeared to seek to undermine one another's authority in relation to determining the needs of the local population. The GP called upon his 'privileged' knowledge as a professional working in the area. This was, in turn, discredited by the HAZ manager, who asserted that there were aspects of the patients' lives and health to which the GP has no access – and therefore that the GPs' claim to expertise was of limited validity.

Several of the GPs in this PCG had a history of confrontational relationships with the Health Authority over fundholding. In addition, certain GPs had supported an alternative PCG configuration that would have allowed them to be grouped with like-minded GPs that the Health Authority had rejected. It seemed as if the GPs saw themselves as having little invested in the new structures, and hence there was little incentive to work with management.

Many (if not all) of the 'negative cases' in which consensus and local collaboration broke down revealed 'cracks' in the idea of stakeholder power sharing. The complexity of the techniques employed to establish and maintain consensus between different perspectives depended on support from all sides (such as overall recognition and assent to imprecise definitions). As previously suggested, such support tended to break down when one group (usually the GPs) perceived itself to be either powerless, or not able to manipulate

the structures sufficiently to serve their own agenda (or perceive themselves as being able to do so).

6.7 Discussion: How can the consensus building and co-operation observed in Casterdale be understood?

In drawing this chapter to a close, I have two distinct aims. First, I will present several models to account for the particular instances of co-operation and consensus building that I observed in the setting. Secondly, I will outline ways in which my data's 'micro' level interaction relates to the 'bigger sociological picture'. I propose that these data have potentially important contributions to make for both our understanding of the development of professions, and the implementation of public policy.

The present reforms have been shaped by the context of nearly constant organisational change and restructuring within the NHS (Ham, 1999). March and Olsen (1983) noted that successive British governments have engaged in "comprehensive reviews of administrative structures and practices" (p. 281), and organisational change has increasingly become part of one's 'normal' experience and expectations. Thus, NHS reform has sometimes been interpreted as a cyclical process pertaining more to maintaining status quo, than to achieving any *real* change (Brunnson; 1989, Meyer and Rowan; 1977). From such a perspective, reforms are seen as essentially incapable of delivering on their promises; reforms rather rely on people's short memory span, and the attractiveness of any new promises for their success. Reform's primary role is seen to be

to maintain members' organisational faith by focusing their attention away from existent weaknesses towards future possibilities.

6.7.1 Models of 'Reform Fatigue' – being sick and tired of change

Within a model whereby 'reform' has become so routinised, it is possible to imagine that conflict between managers and GPs might not be overly prevalent. If actors perceive reforms as unlikely to result in significant change, they will be less inclined to either actively engage with, or be concerned about initiatives. Local actors may 'go with the flow' of centrally driven reform measures because their experience tells them that the initiatives are unlikely to affect local practice to any great extent. Thus, the ideas and priorities that were presented in the White Paper may not have been 'thrashed out' between local professionals and managers because it was deemed unlikely that they would survive, and more likely that they would soon be replaced by yet another new set of initiatives¹¹⁴.

One might therefore assert that reforms provoke little overt confrontation because local actors are tired of change. They do not believe that any 'real' change will occur, and therefore do not actively engage in the implementation of concepts.

¹¹⁴ Such predictions would seem to hold some merit. Less than three years later (in less time than it takes to finish a thesis!), a new set of reforms had been introduced. These initiatives superseded many of those introduced through *The New NHS*, changing the rules and boundaries yet again. These initiatives are outside the scope of this study.

6.7.2 Maintaining the status quo and protecting important and pre-existing 'network' relationships

These data provide little evidence to suggest that the reforms were being actively and openly opposed at the local level, although the initiatives were receiving a certain level of critical attention. Local implementation seemed to involve most local actors acknowledging the key reform objectives, and subsequently working to incorporate the reforms successfully into working practices, while also maintaining (and possibly strengthening), local working structures. Systems of consensus and co-operation were being built between local management and GPs, with the seeming result of facilitating the different stakeholders' continual pursuit their own agendas. This is in line with Griffiths and Hughes (1999) proposal that managers and doctors adopt 'alternative' languages that reflect differences in their aims and priorities as a strategy to deal with potential conflict resulting from reforms.

It is, however, important not to under-estimate the medical profession's cultural authority to limit the impact of any proposed changes (Griffiths and Hughes, 1999). Although doctors may be challenged by managerial incursions and bureaucratic arguments, the cultural authority of the medical profession can serve to limit the significance of such challenges. Harrison et al (1992) suggest that the cultural authority granted to doctors undermines the power of other groups without requiring overt confrontation. The cultural dominance of doctors is such that other actors are unlikely to consider the possibility of introducing initiatives that might challenge the authority of the medical profession. Thus,

modes of discourse become so embedded as to actually shape what is deemed 'thinkable' or 'doable' (Dingwall and Strong, 1985).

On this basis, the absence of overt confrontation between managers and GPs in Casterdale might not reflect a simple 'reform inertia', but rather the ability of the GPs to protect the status quo that they perceive to have served both themselves and their patients well. GPs may sometimes be able to prevent the consideration of structural changes, thus enabling them to conflict at a deeper, ideological level. This explanation does not, however, fit particularly easily with the Casterdale data. Local actors did not totally ignore the reform initiatives, or the ideas behind them. At the same time, their application did not seem to provoke the expected level of confrontation between managers and professionals.

One of the shortcomings of the traditional professional/managerial 'conflict' model is that it is based upon an assumption of a single hierarchical system of control, in which one group will necessarily dominate all others. Such models have typically presented professional and bureaucratic models of control as oppositional, and periods of reform as opportunities in which existing power structures might be challenged. Flynn, Pritchard and Williams (1994), however, found that business enterprises are increasingly likely to be organised according to 'network' principles that emphasise collaboration and organisational interdependency, rather than around vertical (hierarchical) integration.

Such network systems are particularly prevalent where relationships are long-term and involve high levels of co-operation around work, the pooling of resources, burden sharing and reciprocity. Ouchi (1991) referred to such systems as 'clans'. This organizational structure resonates strongly with the Casterdale data. These models of networked relationships reflect Durkheimian principles of 'organic solidarity', in which individuals make different, but interrelated contributions to a collective product. In such 'clan' or 'network' systems, performance ambiguity will often be tolerated, and goal conflicts between actors minimised, in order to protect the complex, valuable and long-term existing relationships.

Hughes and Griffiths' (1999) analysis of the Conservative reforms of the early 1990s conceptualised the introduction of a system of 'contracting' within the NHS as "purposive action, embedded in ongoing systems of social relations" (91). Perhaps the formation of PCGs might be understood in a similar way.

Local actors were motivated to make the reforms successful; both managers and GPs perceived potential to further their own agendas. Furthermore, the background of 'near constant reform' within the NHS provided actors with a vested interest in protecting existing and newly forming social networks, regardless of the particular outcome of the present reforms. The creation of an atmosphere of consensus and co-operation in relation to the reform initiatives in Casterdale can therefore be understood as strategic action on the part of local actors. GPs and managers were able to incorporate ideas from the reforms that supported their own agendas, while also protecting the important local,

working networks that their experience tells them are likely to outlast the particular present initiatives.

I am aware, however, that the relative absence of overt conflict and confrontation in my data could be more the result of the formality and public nature of the settings that I observed, rather than any powerful underlying consensus. From my observations, it sometimes seemed as if the *real* work of decision making had to be taking place elsewhere, and that these meetings were simply being used as an opportunity to present decisions; the official meetings were being used as ‘showcases’ for decisions that were being ‘hammered out’ elsewhere.

6.7.3 Summary

Through this chapter, I have illustrated that the ‘inertia’, or ‘failure’ that is often attributed to reform initiatives may actually often reflect quite careful interaction between local stakeholders, rather than simple failure to achieve official objectives. As such, I assert that considerations of policy are appropriately focused on the micro level, as it is here that policy is actively constructed. Ham (1992: 36) proposes that it is vital to consider negotiation and bargaining within the policy community in order to better understand its detailed processes. Failure to consider the detailed application of policy can lead to simplistic conclusions that policies have fallen short of their goals, rather than appreciating that it is the role of local actors to shape goals into acceptable and workable structures.

Regardless of the particular reform initiative, change within the health care arena tends to be incremental and based upon small, marginal adjustments (Ham, 1992). There is a tendency towards the status quo because of the existence and importance of a complex network of local interest groups. To this extent, Ham's analysis and mine concur. I would, however, contest the significance that Ham attributes to the gap between official policy objectives and local interaction and implementation. The Casterdale data suggest that purposeful and complex policy is implemented at the local level – even when it may initially appear as if the policy has failed.

I began this chapter by recounting why professional/managerial co-operation is not generally expected during reform initiatives. Whereas previous models have tended to conceptualise the power distribution between doctors and managers as an isolated 'zero-sum' game (Klein, 1995), I suggest that actors often appreciate the importance of the protecting the local network, and may be willing to sacrifice a particular 'battle' in order to win 'the war'.

The body of the chapter was spent outlining both how and why the GPs and managers in Casterdale appeared to work so diligently to create and maintain co-operation and consensus within the preparation and implementation of PCGs, as well as several instances where consensus either broke down or was never appeared to be actively sought.

By and large, however, the implementation process for PCGs (between GPs and local Health Authority managers) can be seen as one in which different local stakeholders employed a variety of techniques and mechanisms to facilitate consensus and collaboration wherever possible. I have suggested that this is because both GPs and management recognised considerable potential within such consensus through which they might pursue their own agendas. Instances in which consensus building and collaboration broke down, or were rejected, seemed to result from a perceived power imbalance; one actor discerning that they had less to gain through collaboration than from a more isolated pursuit of their own agenda or objectives.

The issue of control over both resource allocation and practice is at the centre of *The New NHS*' rhetoric. The White Paper described both a decentralisation of decision making to local professionals, and the establishment of rigorous structures for ensuring high quality practice. These two objectives suggest quite different trajectories of control. Both GPs and management seemed to appreciate the opportunities afforded them through such imprecision, and largely sought to avoid confrontation that might undermine their own (quite distinct) power strongholds.

7. Discussion

In this chapter, I wish to return to the issues raised within the three data chapters, and to identify places where my data address questions posed by the existing literature. I will also indicate the direction that these data lead us in regards to future research. I will consider the data alongside the stated policy objectives, as well in relation to the context in which the reform initiatives were implemented. I do not intend to calculate whether this particular policy has ‘succeeded’ or ‘failed’, but rather to consider the prioritisation of particular reform initiatives, and locally initiated mechanisms that were intended to deliver the reform objectives.

Two questions will drive this chapter:

1. ‘How were government objectives translated from official policy into local practice?’
2. ‘What effects might the particular implementation have for the future of professionalism, health care provision, and the delivery of the welfare state?’

7.1 The Policy – a presentation of ideas

The incorporation of change initiatives within organisational structures has become an important phenomenon for sociological consideration. Organisational change has increasingly become seen as a normal part of life, rather than as a rare upheaval (Meyer and Rowen, 1977; Brunnsen, 1989; Ferlie, 1997), and seems to have been largely accepted as necessary for development and progress. Thus, contemporary organisations and institutions often now seem to be both defined and judged by their apparent ability to adapt to a changing environment.

In the midst of all of this change, however, the general faith in the ability of reform measures to make any 'real' difference, and to steer us off of our current trajectory, seems to have faltered. Reform scepticism has become common in an arena that has experienced as much upheaval as has the NHS.

The structure of the NHS has been constantly evolving since 1948, and this process has intensified since 1979 (Ferlie, 1997). The NHS is an enormous organisation that is both extremely complex and expensive. In addition, the system faces high levels of demand on the part of citizens who have accepted and incorporated the institution's ambitious stated aim of 'providing comprehensive care, free to all at the point of delivery.'

Balancing these factors has proved to be a challenging task that has provoked successive reorganisations since the establishment of the system. Instigating reform is, however, an expensive and uncertain process for the government, with no guarantee that measures will receive the necessary level of public support.

The problematic concept of 'reform' is acknowledged within the White Paper, *The New NHS* (1997). The document is framed around assurances that the proposed reform is 'real' and focused, and will lead to meaningful change and improvements. It sets out many reassurances that costs and disturbances associated with the reforms will be minimised in the face of likely critiques that additional reforms are simply a waste of time and money.

“The Government certainly doesn’t want to see reorganisation for the sake of it.” (The New NHS, 1997: 50)

“This White Paper marks a watershed for the NHS. It sets a clear direction for the NHS as a modern and dependable service. But it will not mean a wholesale structural upheaval, generating costs and disruption that get in the way of patient care” (The New NHS, 1997: 76)

Considerations of reform initiatives often aim to assess the extent to which reform measures have ‘succeeded’ or ‘failed’ to achieve their stated goals (Robinson and LeGrand, 1994; Ferlie, 1997). Such analysis rests on the notion that policy is always created centrally with clear intentions as to identifiable and measurable outcomes, and is then simply applied locally. Such models tend to give little consideration to the power and influence of local actors in shaping policy. Thus, policy is deemed to have failed in instances when outcomes are not clearly specified, as well as when local actors are able to significantly influence the outcome of the policy. The present study did not start from such a position of evaluation, but assumed quite a different perspective. I concentrated on the way that policy was adopted and ‘made’ at the local level, by those who were charged with incorporating policy to their daily practice. I spent considerable time incorporating the idea that health care reform is the result of an ongoing process of compromise between the state and other key bodies – particularly the medical profession (Mays, 1997). The central role played by GPs in the implementation of current reforms led me to prioritise the professional history of general practice within my analysis.

A consideration of the ways in which policies are constructed (in this case between GPs and Health Authority managers at a local level), is likely to suffer fairly significant limitations without some consideration of the larger structural context (O'Toole and O'Toole, 1981; Hall, 1997). Starr (1982: 8) states that, "The development of medical care, like other institutions, takes place within larger fields of power and social structure." An informed analysis of micro level interaction requires the 'action' to be set within the existing 'structures' - such as the overarching philosophies of state and welfare provision, and the power relations between different groups. I anchored my empirical research in the existing knowledge regarding both health care reform (on an international, as well as a national basis) and professional claims making. I sought to utilise the opportunities offered by the reforms to address issues from these literatures.

The 'stated' or official policy goals and objectives are a product of existing power structures and context, and are therefore central to analysis. I did not, however, assume that official policy goals reflected any 'real' reform goals. Rather, I propose that the official objectives of any policy are produced for specific purposes, for specific audiences, with intended reactions. Although it would be very interesting to construct a model of what the government *really* intended to do through the reform measures, sociologists cannot read minds. Analysis is therefore more appropriately focused on the enactment of policy.

Ferlie's (1997) analysis lends support to the idea that it is difficult to accurately identify the motives behind reform initiatives. Such an analytical approach would require a

construction of the state as a homogeneous entity with unified aims and goals. The state is rather an amalgamation of different interest groups and organisations who are creating policy within an active (and fluid) political domain. We can, however, learn a great deal from a careful consideration of policy as a social construction. Existing structures and context will shape the development of official policy goals, such that only certain objectives remain justifiable. Official policy goals will, in turn, determine the options available to actors within the local setting, and will contribute to the recreation of social reality. Policies are the result of political trading, rather than resulting from ideological contemplation (March and Olsen, 1989). They are part of a complex feedback mechanism, with actors having differential power to mould the process at particular stages of its creation and implementation.

Although my research clearly focuses on local applications of policy, I recognise that it is always important to consider the context within which policies are situated. I have framed my analysis by the national political context, but only made implicit references to the contextualisation of policy beyond this. Policies also sit within, and are shaped by, an international (or global) framework, and both national structures and international movements significantly structure the provision of health care.

The existing literature on reform measures (based upon empirical research into previous reforms) has identified trends relating to the organisation and reform of health care systems - both over time and between different states (Hafferty and McKinlay; 1993, Light; 1997b). The organisation of health care provision has become increasingly

paradigmatic, with analogous ideas being adopted in distinct forms within different systems (Dixon, Holland and Mays; 1998). This, in turn, shapes the policies that are developed and implemented at the provincial level. Rose and Miller (1992) conceptualise such trends as ‘political rationalities’, or constantly developing notions of appropriate power structures and mechanisms.

Ferlie (1997) has identified one such paradigm as being the international trend towards large-scale organisational and managerial change. Moreover, Flynn (1992) identified a tendency for health care systems to be reorganised in the name of cost containment, and for reforms to be focused upon the limitation of medical autonomy. The prioritisation of evidence based medicine and the increasing role for primary and preventative care are also international movements, and there are influential *international* bodies (such as the World Health Organisation, The United Nations, Red Cross) who play key roles in moulding *national* policies.

These political rationalities (at each of the local, national and international levels) are modes of discourse that shape thinking about what power is, what it should do, and how it should be accomplished. The introduction of reform initiatives for the NHS instigates an alteration of the ‘political rationalities’ in relation to health care provision. The details of such a shift, and the means by which it was negotiated at the level of action are the heart of this thesis.

A consideration of the policy document itself (*The New NHS; modern, dependable*), in the context of the existing literature from previous reforms identified three pertinent changes -

1. The policy emphasised the importance of obtaining and providing 'efficient' and 'effective' health care, thus adding strength to links between the cost and provision of care.
2. The policy was designed to allow the government to legitimise shifting responsibility for decision making to local professionals. In so doing, it was able to redefine its own role and responsibilities.
3. The policy promised to improve the delivery of quality care throughout the service. Thus, the government was able to engage the notion of 'quality' as a justification for a standardisation of resource allocation and more vigorous regulation of professional practice.

The policy makers' stated intentions, and their possible effects are only half of the story. My data reveal that local actors, namely Health Authority managers and GPs, were able to mould policy initiatives to support or advance their own position.

Leaving aside the managers, GPs engaged with the 'efficiency' and 'effectiveness' initiatives as a continuation of previously initiated local measures (namely the TCG) that

had expanded their role in relation to resource allocation and controlling clinical practice. Furthermore, GPs did not appear to struggle against the limited implementation of initiatives designed to shift responsibility for decision making outwards to local professionals. GPs seemed to appreciate some advantage to ‘gradual’ movement in this regard. Similarly, they gained from retaining a certain level of ambiguity with regards to key reform initiatives such as ‘quality’ and ‘clinical control’. GPs worked to avoid confrontations that would compel the formation of more concrete definitions.

The remainder of this chapter will take the 1997 reform, *The New NHS*, as a case study of recent reform initiatives, and will reflect upon the implementation of policy at the local level – particularly in relation to the three themes emerging from the written policy and existing literature. I will ask, ‘What can be learned from an analysis of the power relations of the actors at the level of action?’, ‘How is the implementation affected by the particular agendas of the different groups?’, and ‘How will the implementation of this policy shape future agendas?’

7.2 Putting ideas into practice - Technologies, Agendas and Power

This thesis has been concerned with the local preparation for, and implementation of the White Paper, *The New NHS*. Policy has been described as a process through which laymen (policy makers) attempt “*to redefine values and to change action about some matter over which some occupation holds a mandate*” (Hughes, 1971: 290). In turn, research into the history of NHS reform initiatives has revealed that such measures have often had only limited success in achieving their stated goals (Dopson, 1996). Influential

actors in the local realm (particularly the medical profession) have tended to have a sufficiently strong power base to limit the impact of reform measures (Ashburner, 1995).

Rose and Miller (1992) coined the term 'governmental technologies' to describe the mechanisms by which centrally initiated 'rules' are operationalised. Little academic attention has, however, been paid to the particular means by which the objectives of the policy are translated into local action - both through government initiatives, and local managerial work. I chose not to focus on extent to which the 'abstract' policies (or policies as they were originally formulated) succeeded or failed, but instead considered the behaviour that was actually occurring at the local level. My analysis is concerned with government mechanisms to pursue official goals, as well as the interaction between official policy and the distinct agendas and resources of local actors. I argue that this interaction is key to the tangible expression of applied policy. In essence, local actors fashion the 'making' of the policy at the local level both within and according to the constraints that are officially laid down.

In the following sections, I wish to draw together (and make links between) several of the themes raised in the data chapters through a discussion of the local operationalisation of reform objectives. First, I will consider how local action reflects the stated policy goal of improving the efficiency and effectiveness of health care. I will also discuss the use of improving 'quality' as both an effective rallying point for the reform initiatives and a basis upon which to strengthen government clinical control. Finally, I will explore the

contribution of *The New NHS* to the ‘unspoken’ objective¹¹⁵ of reducing government responsibility for providing a welfare state (in this instance, focusing on health care) with an ever-expanding remit.

7.2.1 The New NHS as a means of delivering affordable, efficient and effective health care

The New NHS is quite succinct in its objective of improving the efficiency and effectiveness of the care provided.

“...to drive efficiency through a more rigorous approach to performance and by cutting bureaucracy, so that every pound in the NHS is spent to maximise the care for patients.”

(The New NHS, 1997: 11)

“The government is determined that the services and treatment that patients receive across the NHS should be based on the best value for money (clinical and cost effectiveness). At present there are unjustifiable variations in the application of evidence on clinical and cost-effectiveness.” (The New NHS, 1997: 56)

The objectives may also usefully be interpreted as elements of a battle to control the cost of providing health care. By focusing on ‘effectiveness’ and ‘efficiency’, however, the reform rhetoric avoids engaging with the notion of ‘cost control’ measures, while continuing efforts to strengthen accountability structures. It was not always clear,

¹¹⁵ Derived from a consideration of the reform initiative that is informed by the history and sociological theory.

however, that the actors taking part in the local implementation of policy initiatives interpreted any significant connection between efficiency measures and cost control.

One important contextual factor for local interpretation of *The New NHS* was the centrality that had been placed on cost control within the remit of the TCG. Flynn (1992) identified a tendency for health care reforms to focus on cost-containment efforts and attempts to limit medical autonomy. This existing locally formulated structure had been surprisingly successful in controlling practice, and thus costs. Moreover, the GPs who were members of the TCG had worked diligently to monitor spending, and the initiative was successful in keeping prescribing costs within budget. These GPs seemed keen to apply their successes to the new reform context.

Thus, the amalgamation of practice budgets and the ways in which these could be controlled by the PCGs quickly became key issues in the implementation meetings, and concern over these issues was expressed in both GP and management interviews. The data suggest that Casterdale GPs had largely accepted the notion of cost control in health care provision before the advent of PCGs. With the birth of the new structures, those GPs who had been actively involved in the TCG generally seemed to accepted the expansion of their successful cost control measures into wider resource allocation decisions.

The ability to augment government control over spending in a manner that is publicly justifiable is, in itself, an important part of many reform measures. The idea that reforms are conducted within the political sphere, and may therefore be shaped by the need for

justification, as much as any search for efficiency (Ferlie, 1997), is important to this research. The new Labour government may have felt that it would be easier to establish a mandate to address 'efficiency' and 'effectiveness' in the NHS, in contrast to the perceived Conservative fixation with reducing costs. If 'efficiency' and 'effectiveness' were to be achieved then the government might be able to avoid engaging in a more politically sensitive form of cost control - rationing.

Policy rhetoric is not only important in relation to public opinion, but also in terms of gaining crucial professional collaboration for reform initiatives. GPs have historically been important to the success of proposed NHS reforms. Although GPs have often been described as being quite ineffective at utilising their collective numbers to pursue common objectives (Horobin, 1983; Webster, 1988), they have sometimes been able to collectivise in order to prevent change not deemed to be in their interest. GPs have certainly demonstrated an ability to 'stall' changes that they do not support (Webster, 1988; Levitt, Wall and Appleby, 1995; West, 1995).

Klein (1995) suggests that GPs are being incorporated into change measures with the intention that in so doing, professional dissent as described above will be made more difficult. Developing an 'inoffensive' rhetoric (efficiency and effectiveness rather than cost cutting and rationing) is an important way to pursue incorporation. It may not even be necessary to convince the entire profession, but rather to target influential individuals. Incorporating the profession's 'leaders' (or activists) reduces the likelihood that this already disparate group will be able to mount effective opposition.

One of the important findings to emerge from this research was the precarious nature of the relationship between the government and the profession's leadership. Several Casterdale GPs had been directly involved in the political movement to end fundholding, and many of their non-fundholding colleagues had supported their work by joining the TCG. The White Paper left these GPs expressing feelings of abandonment; the new Labour government did not adopt their model of commissioning (and commissioning groups like the TCG) for the 'new' NHS (as they said they had been promised). During my fieldwork, these GPs repeatedly expressed feelings of disillusionment because the way that the PCGs had been outlined was not the structure that they had worked to build.

The long-term effects of such disillusionment on the part of professional 'enthusiasts' would be a potentially valuable continuation of this research. Both the avid 'non-fundholders' and the smaller group of disaffected fundholding GPs portrayed themselves as having been betrayed within the new system. The data from this research suggest that deep-seated feelings of discontent were significant, and influenced the nature of the official GP involvement in the new organisational structures.

Gaining GP support for reform initiatives was also potentially important beyond establishing professional compliance. If incorporated, GPs could play a key role in gaining public support for reforms. As outlined in Chapter 2, the public generally appears to support the NHS, and to have grown sceptical of reform measures. The government therefore needs to validate the particular initiatives that are introduced. The

general aura of public trust in professionals (in this case, GPs) as experts can be a useful way to legitimate and facilitate the reform measures.

Heath (1995), however, outlines potential difficulties if the public perceives the government to be using GPs to control costs. Professional discourse establishes GPs as patients' advocates, rather than government agents. GPs' role as the 'patient's advocate', however, rests on an individualistic philosophy of health care in which it is the doctor's duty to seek the best treatment for their patient regardless of the resource implications - even where these could restrict the care available to others (Petchey, 1996). Furthermore, GPs' effectiveness as gatekeepers rests on public trust that they will do what is right and best for the patient - regardless of costs. Any increase in GP involvement in 'rationing', or in managing the resource implications of clinical decisions, needs to be carefully presented in order to avoid a detrimental loss of public trust in the role of the GP¹¹⁶. If GPs are seen to be prioritising cost concerns, then it is likely that such trust, and the associated strength of the doctor/patient relationship will diminish. GPs' referral decisions are more likely to be called into question, thus weakening the gate keeping/referral system.

GPs' involvement in the particular initiatives outlined in *The New NHS* sparks additional difficulties. The formation of PCGs supports a 'collective' image of health care, rather than one that is based on notions of individualism - particularly in relation to the work of

¹¹⁶ Saks' (1998) analysis of GP professionalism suggests that GPs' role as patients' advocates should be considered from the perspective of the extent to which this supports GPs' 'altruistic' claim to professional status.

general practice. In PCGs, GPs are enjoined (as board members) to make resource allocation decisions for the entire 'local population', rather than simply for their own patients. In addition, the PCG structure (at least on the surface level) requires that GPs (and other board members) prioritise certain types of treatments based upon the potential collective benefit – rather than individualistic effectiveness.

To this extent, the introduction of PCGs has the potential to prove challenging to the basis of GPs' professional claim as advocate for their own patients. Walby and Greenwell (1994) would, however, dispute this conclusion, and rather suggest that doctors have always been involved in making resource allocation decisions, but have previously articulated these decisions in terms of clinical 'need'. In *The New NHS*, these matters may be conceptualised in terms of 'effectiveness' and 'efficiency', rather than as driven by patient need.

The 'subtle' shift towards collectivism, and the new role for GPs as providers of collective health care, reflects not only a change in the work of GPs – but also the responsibility of the state and citizens. Stewart and Walsh (1992) see such cultural changes as being key government objectives behind the reform initiatives, but also propose that such cultural change will take longer to implement than the simple introduction of the necessary mechanisms. Although any move towards 'health' and away from 'treatment of ill-health' was largely left to one side within this research, the redefinition of the role of the state emerged as central to the way that the reforms were

interpreted and implemented at the level of action. This redefinition is the focus of the following section.

7.2.2 Incorporating professionals and reducing state responsibility

The New NHS describes increasing the role played by local professionals in managerial tasks as one of its main objectives. Enhanced professional involvement is linked with promises that decisions that are made at a local level will provide a better reflection of the needs of the local population.

“Local doctors and nurses, who best understand patients’ needs, will shape local services. (The New NHS, 1997; p. 5)”

“For the first time in the history of the NHS all the primary care professionals, who do the majority of prescribing, treating and referring, will have control over how resources are best used to benefit patients.” (The New NHS, 1997; 37)

These statements might be interpreted as evidence that the government intends to empower local clinicians, and that the government supports the idea of ultimate professional autonomy. Such an interpretation does not, however, sit easily with two other reform ‘objectives’ identified through this research – namely improved centralised control over the cost of health care, and formalised, mandatory systems of professional practice audit. Although ‘devolution’ tends to be an integral part of reform initiatives that are based upon ‘managerialism’, this may support a dependent rather than

autonomous culture; power need not necessarily be devolved along with responsibility (Clarke, Cochrane and McLaughlin, 1994).

As already outlined, the government's decision to include devolution initiatives within the 1997 reforms may reflect a recognition of the value of professional 'expertise' in justifying difficult (or potentially unpopular) decisions. Rose and Miller (1992) highlight the potential for professional 'expertise' to be used to 'persuade, educate, induce and encourage' the public in relation to reforms. GPs form a network between the welfare state and the population, with 98% of people in Britain being registered with a GP (Larkin, 1995). If the government can incorporate GPs into the reform mechanisms, then they may be able to use them to influence their patients (the public) to adapt to any changes introduced in the system.

The potential for professionals to expedite the state's delivery of public services can, however, also exceed acting as policy 'middle men'. Halliday (1987) asserts that professions are 'repositories of knowledge', through whom governments can access the faculties for effective government. Professionals have the cultural authority (based both upon their expertise and the notion of vocation) to influence the expectations, belief and desires of their clients (Starr, 1982), and are influential in defining how people think about and approach key areas of their lives. Having doctors involved in resource allocation decisions may facilitate the successful movement towards limiting individual care in the name of a collective good.

Hanlon (1999) proposes that professionals' cultural authority makes them potentially valuable to the state; professionals have the capacity to act as regulators of central areas of social activity. The ability of professionals to shape what people believe is possible, what they desire to happen, and what they expect the state to provide, makes them influential agents. Starr (1982: 14) also notes that professionals' authority allows them to shape understandings such that they "*create the conditions under which their advice seems appropriate.*" In a sense, professionals are in a position from which they can create or reinforce their own power, thus making them nearly indispensable. This professional authority can serve both as a useful mechanism for defending the position of the state, and that of the professions themselves.

The augmentation of the managerial role for professionals (in this case, GPs) as described thus far does not, however, assume any change to the role of the state as related to the provision of services. Policy makers used professional authority to legitimise decisions and to shape the public's expectations of what should be delivered/offered by the service. This does not necessarily alter the government's responsibility, or the relationship between the government and GPs.

Beyond the 'incorporation of expertise' description given above, *The New NHS* may also be understood as a government attempt to reduce their own role in decision making and resource allocation in relation to the NHS (Ham, 1998). An expanding government remit increases the areas over which they can claim influence and power, but also over which

they are deemed to be responsible. Thus, ever-increasing expansion may eventually dilute the power of the state through an overload of responsibilities.

There are specific areas where the state is likely to seek to reduce their involvement. In particular, the British government is faced with exceptionally high public expectations in relation to welfare services (Giddens, 1998), and these induce considerable pressure. Furthermore, British health care provision is particularly problematic in that it is burdened with the notion of the unattainable goal of providing 'health for all' (Kelly and Glover, 1996). Public expectations will always remain somewhat unfulfilled, creating a scenario in which the state may not receive sufficient 'credit' for their involvement to make it particularly worthwhile.

Halliday's (1987) research regarding the relationship of lawyers and the state (in the US) provides a potentially applicable analytical framework for *The New NHS* reform initiatives. He proposed that governments face ever increasing demands and expectations on the part of their citizens as to what they can and will provide. Thus, the state becomes unable to successfully fulfil all the expectations made of it, and instead engages professionals to 'manage' or assume responsibility for key areas of work. Such a move is intended to alter expectations of the state. By enlisting professionals to decide how to spend available money, the government is able to reduce their own responsibility (Harrison and Pollitt, 1994).

Halliday suggests that the US government has passed much of the responsibility for defining and delivering justice (an area that has become seen as a central state responsibility) to the legal profession. Hanlon's (1999) analysis of the relationship between British lawyers and the state goes further still; he draws links between the government's desire to limit the expansion of the welfare state and initiatives to instil greater control over professional practice. The reliance on professionals creates a complex relationship in which neither the state nor the profession has absolute authority, but is dependant on one another for their power and privilege.

Previous government attempts to devolve responsibility (and perhaps blame) for difficult and unpopular policy initiatives within the health care realm have not always proven particularly successful. Clarke, Cochrane and McLaughlin (1994) provide the Community Care Act and Poll Tax as two examples where the government was not able to effectively shift the blame away from the centre, and where the actions instead created additional attention and criticism.

The Casterdale data would suggest that the incorporation of GPs into decision making was purposive on a more micro level. The delegation of tasks and responsibilities to professionals at the local level was not, however, universal. Rather, certain aspects remained centralized, while others were consigned to GPs. Hughes' (1971) notion of 'dirty work' suggests that such decisions may reflect power imbalances. The data also indicate, however, that GPs were often able to resist taking on unwanted tasks.

The two explanations for the further incorporation of professionals into decision making structures (in order to provide legitimacy for changes, or to facilitate lessening government responsibilities) are quite different, but both draw upon Halliday's (1987) notion of 'governmentality'. In both Hanlon (1999) and Starr's (1982) model, the government seeks to build on professional authority, and professionals are brought within a 'state governed system'. Ham (1998), however, conceptualises the government's intentions as being only to 'empower' professionals in areas deemed to be politically difficult, and in which the state wishes to reduce its own involvement.

The implementation of 'decentralisation' initiatives to local professions offered an opportunity to consider these two alternative conceptions of the state. The language of *The New NHS* clearly delineates an enhanced role for professionals in decision making processes and structures. It is not, however, clear from the document itself either what this augmentation will entail, or what its effects may be for GPs. A consideration of the implementation of the policy in Casterdale is therefore useful for understanding such initiatives in relation to the professional agenda.

As outlined above, *The New NHS* policy documents describe greater professional involvement in decision making and management, with seemingly little consideration given to the idea that the professionals might not welcome this new role. The GPs initially expressed reluctance to become involved in PCGs, and to take on additional workload. They asserted marked scepticism regarding the likelihood that the government would be successful in finding enough GPs to fill places on the PCG boards. Greenfield and Nayek (1996) found similar GP reactions to previous reforms, and proposed that

when an occupational group (such as GPs) have not actively sought to expand their jurisdiction into a particular area, any suggestion that they might do is likely to be interpreted negatively. Professionals tend to focus on the potential constraints rather than opportunities.

In spite of original protestations, by the time that the PCG boards were actually formed they all had their full quota of GP members – seven on each of the boards. In addition (at least initially), all of the PCGs were chaired by a GP, although two of these resigned within a few months of taking up the posts¹¹⁷. Furthermore, all of the members of the TCG Forum became members of a PCG board. Despite several lengthy discussions at TCG meetings before the PCG board elections took place, in which general disappointment and lack of interest in the new structures was expressed, the existing GP ‘leaders’, ‘enthusiasts’ or ‘careerists’ (depending on one’s perspective) remained involved.

It would seem that at least a certain ‘echelon’ of GPs saw some potential benefits from taking on more managerial roles. FitzGerald (1996) proposed that ‘clinical management’ roles offer doctors the opportunity to inform major decisions that shape the delivery of health care. Reform measures provide scope for GPs to be increasingly influential in decision making (Griffiths and Hughes, 1999). GPs who had previously sought managerial involvement through the commissioning and GP fundholding initiatives, generally acquiesced with the new system with the formation of PCGs.

¹¹⁷ One of the GPs Chairs was then replaced by a representative from Social Services.

The GP leaders' expressed willingness to take on greater managerial roles was not mirrored by any widespread change regarding the nature of general practice work within the setting. GPs and managers both described a general reluctance on the part of 'ordinary' GPs to get involved in more 'managerial' or 'bureaucratic' work. Their descriptions were, however, only supported by anecdote and supposition rather than any concrete 'evidence' of such reluctance. GPs were all officially involved with PCGs simply through their membership, but there was little indication of an active communication process between either the TCG or the PCG board members and 'ordinary' GPs about the managerial work being done on their behalf.

McNulty et al (1995) describe every reform as providing some clinical 'winners' and some 'losers'. Thus, the GPs who chose to become actively involved in PCGs may be seeking to protect their status as 'winners'. One way to do this is to limit the involvement of other GPs, thus protecting one's own privileged position. The active involvement of a relatively small number of 'careerist' GPs within decision making structures might, however, contribute to new stratification and divisions within the profession. On the other hand, Larson (1977) contends that 'professional homogeneity' is an ideological concept, rather than a 'true' source of collective strength. Either way, the involvement of 'careerist' GPs in health care management formalises and exposes professional hierarchies, whether or not it actually creates them.

The transfer of GP personnel from the existing structures to the newly forming PCGs may have contributed quite significantly to the extent to which PCGs 'blend' the stated policy objectives and current ways of working. The extent to which reforms actually change the way that people work beyond the initial introductory flurry has been (as I stated at the beginning of this chapter) a central concern within policy research. Dopson (1996) proposed that the reforms of the early 1990s had little long-term effect; eventually people returned to operating in a similar way to how they had before the reforms.

My research focused on the preparation and initial implementation stages of a reform initiative; I make only very limited suggestions as to whether initial activities and changes will lead to long-term change. I do, however, propose that the centrality of the same professional personnel might be a contributing factor to any restoration of previous structures. The importance of the incorporation of such individuals suggests that rather than this indicating a policy failure, the 'fusion' of present structures and official objectives is an appropriate subject for conscientious deliberation.

'Collaboration' emerged as an important mechanism by which local actors mediated the official objective of decentralisation within this local setting. During the fieldwork period, most of the issues 'passed down' from the government to the PCGs were subsequently 'passed back up again' to collaborative structures between PCGs.

Commissioning was the most well-defined of such structures, building closely on the pre-existent TCG. Clinical governance, prescribing and other PCG issues also became 'overseen' by cross-PCG structures.

The idea of collaboration between PCGs received overt support from both GPs and managers during the fieldwork period. GP members of PCG boards described collaboration as a means of reducing the workload associated with involvement in PCGs, as well as being a way to moderate the effects of new roles and responsibilities.

Managers outlined the extent to which collaboration provided stability while the PCG board members 'grew into' their new roles. Collaboration was facilitated by experienced Health Authority managers and thus minimised the risk that the inexperienced PCGs would move away from government expectations and make far-reaching mistakes.

Some of the PCG members did, however, express frustration with the restrictions imposed by collaboration. In several of the meetings that I observed, the GPs discussed their PCGs' intention to assume greater responsibility in the near future. The power of the collaborative mechanisms, either to enforce decisions taken on behalf of PCGs or with reference to PCGs wishing to 'go it alone' was not, however, clearly defined. The relative power of the PCGs and the Health Authority was also unclear, a situation that created some tension around collaboration. Through much of the transition period, there was apparent uncertainty in relation to the power of individual 'actors' (PCG chairs, implementation managers, chief executives of PCGs, Health Authority managers) and 'collectives' (PCG boards, TCG forum, Collaborative Commissioning Mechanism, Prescribing Advisory Board) to make and enforce decisions.

The New NHS, as has been discussed, proposed an augmented role for GPs within management and decision making. In Casterdale there was evidence of emerging formalised structures to which GPs were allowed (and expected) to contribute. The extent to which these new structures had power to make and defend important decisions remained unclear. The status of the PCGs as subcommittees of the Health Authority placed the final authority for any decisions at the local level, in the hands of civil servants rather than professionals. The highly pressured reform implementation timescale greatly limited the contribution of the newly forming PCGs. Collaboration between PCGs became relevant; collaboration expedited effective working, but also limited the contributions of individual professionals, and the extent to which decisions could actually address 'local' needs. In the next section, I will suggest that central structures continued to be extremely influential in shaping local action.

The implementation of the decentralisation objective within Casterdale seems to lend support to Ham's (1998) critical analysis, rather than that of Starr (1982) and Hanlon (1999). It was not evident that local professionals in Casterdale were being incorporated into high level decision making. It seemed rather that the GPs were included in local management because it was seen as an effective mechanism through which to get them to execute centrally formulated reforms. The timescale of the reforms, the 'fudge' around the authority of the PCGs in relation to the Health Authorities, and the simultaneous strengthening of central control mechanisms would all seem to support such a notion.

This is not to say, however, that the GPs naively embraced their new roles and will work uncritically to deliver the centrally conceived changes. As was described in Chapter 6, the implementation of the reforms in Casterdale was shaped by considerable local negotiation. Bacharach and Lawler's (1980) theory of organisations is based upon the premise that internal networks and coalitions are becoming increasingly important. Such structures develop and act collectively to pursue identified common interests. GPs may, however, also increasingly be preparing for anticipated changes.

While the GPs did not reject participation outright, as might have been predicted (Flynn, 1992; Coombs, 1987), their involvement should be considered in relation to their own professional agenda(s). Although my data do not support the notion that government set out to incorporate professionals into high level management, the history of general practice in relation to such reform measures suggests that GPs are still able to capitalise on this opportunity (Clegg, 2000) to pursue their own professional project.

7.2.3 The New NHS as an attempt to improve quality and to standardise care

Alongside the discussion of enhancing the role of local professionals in health care decision making, *The New NHS* also sets out an express intention to strengthen quality control mechanisms throughout the NHS.

"...to shift the focus onto quality of care so that excellence is guaranteed to all patients, and quality becomes the driving force for decision-making at every level of service".

(The New NHS, 1997; 11)

“A new Commission for Health Improvement will be established to support and oversee the quality of clinical services at local level, and to tackle shortcomings. It will be able to intervene where necessary.” (The New NHS, 1997; 18)

“Primary Care Groups will be expected to help primary care professionals to enhance the quality of their care.” (The New NHS, 1997; 41)

The mechanisms introduced to ensure quality were two-fold and encompassed both ‘macro’ and ‘micro’ elements. On the national level, a new set of institutions was introduced whose purpose would be to produce and monitor appropriate health care agendas, processes and targets. Locally, professional self-regulation was both strengthened and formalised in order that PCGs would be able to deliver agreed standards of care, and to control the practice of their members.

Both of these initiatives (the new national institutions and PCGs) were essentially concerned with strengthening control over clinical practice. The NHS’ traditional reliance on purely professionally driven self-regulation was being called into question with the provision of a more proactive role for the state in relation to monitoring clinical standards. It would seem that the government was seeking to ‘renegotiate’ terms of the ‘regulative bargain’ (MacDonald, 1995) with GPs in which professional autonomy is provided in return for professional regulation. The effect of such ‘renegotiation’ for both the delivery of health care and for the professional project of general practice are of

interest. Any instance in which a profession's license and mandate (see 'professions' section of the literature review) is called into question is an important area for consideration (Hughes, 1971), as such a process has the potential to alter the power of the various interest groups quite dramatically. The regulatory mechanisms being introduced through *The New NHS* initiatives do not necessarily curtail general practice's license and mandate, although these necessitate that it be defended, and possibly redefined.

The policy objective of increasing control over clinical practice should be considered within the context of several heavily publicised medical scandals in which the existing mechanisms of professional self-regulation were shown to be ineffective (See Section 5.2.2). The extent to which greater control over clinical practice can contribute to greater control over costs is also likely to be a pertinent factor.

The New NHS presented 'Clinical governance' as a central aspect of the PCGs' role.

"Professional self-regulation must remain an essential element in the delivery of quality patient services. It is crucial that the professional standards developed nationally continue to be responsive to changing service needs and to legitimate public expectations. The Government will continue to work with the professions, the regulatory bodies, the NHS and patient representative groups to strengthen the existing systems of professional self-regulation" (*The New NHS*, 1997; 59)

Health Authority managers who were responsible for drawing up board agendas before PCG Chairs were appointed included the appointment of 'clinical governance leads' on early agendas (either the first or second meeting, depending on the PCG). Within this

hurried timeframe, each of the PCGs appointed a clinical governance lead. The role of the clinical governance lead and their authority was not, however, finalised during the fieldwork period. Furthermore, the appointment/election of clinical governance leads does not necessarily mean that the PCG board members supported the government's notion of increased self-regulation. It seemed possible that for some PCGs the appointees may not be required to pursue their role particularly actively. In the least, however, the establishment of clinical governance leads demonstrates that there were clinicians willing to take on this role.

The prioritisation of clinical governance and collegial audit within PCGs was mediated by PCG GPs' presentation of a very 'moderate' image of what such control would entail. Peer control was outlined in terms of providing colleagues with the relevant information so that they could regulate and (if necessary) modify their own practice. This construction of clinical governance serves to support notions of an honourable profession. GPs' practice is portrayed as being steered by vocation and altruism. Thus, if supported properly, self-regulation is an adequate control mechanism.

The 'genteel' image of professional regulation was not, however, particularly evident in practice within Casterdale. One of the mechanisms employed to promote more active peer control through *The New NHS* was to aggregate practice budgets within PCGs. Personal GP incomes were safeguarded with the creation of PCGs ('ring-fenced'), while significant proportions of GPs' budgets were added to a 'central pot'. This change meant that the 'rogue' practice of a single doctor could significantly affect the resources

available to their PCG colleagues. This provided GP board members with both the incentive and the justification to be more proactive in collegial audit than professional culture had perhaps previously supported. When practice audit was possible (largely based upon the availability of relevant practice information, such as in relation to the prescribing practices of TCG GPs), notions of professional regulation quickly became prescriptive, rather than facilitative. GPs did not seem particularly tolerant of 'outlying' practitioners once the implications of such practice became clear.

Local, professionally driven control mechanisms appeared to be very effective. The TCG may be considered as a 'pilot study' for PCGs in relation to collegial control. Not only did the GPs involved actively adopt the regulatory roles, the mechanism also proved effective in controlling costs. The TCG was successful in keeping within budget – a scenario that led to frequent public statements of surprise and congratulations from many of those involved. While the GPs seem to have adopted the principle of more active professional audit, they also created a presentation of such work in such a way as to support their professional project.

Hughes and Allen (1993) propose that the objective behind most UK reforms since the formation of the NHS has been to attempt to bring doctors and managers under a common framework of accountability, and in so doing to impose a common structure of control throughout the system. Promoting increased professional accountability may be seen as an alternative mechanism to engaging the market in relation to controlling the cost of health care provision (Honigsbaum, 1979). In a system defined by internal

controls, the government might retain (or even augment) centralised control while at the same time delegating responsibility to the periphery (in this case local GPs). In the next section, I will ask whether or not enhanced accountability necessarily challenges GPs' professional claim.

7.3 The effect of the reform measures for the professional project of general practice

The struggle between the state and the medical profession for control of the health service is well documented (Harrison and Pollitt, 1994; Freddi and Bjorkman, 1988, Moran and Wood, 1993; Scrivens, 1988; Wolinsky, 1993; Ferlie, 1997). It is typically presented as the result of straightforward attempts on the part of the state (through government policies and initiatives) to increase control over the profession, and in so doing, to increase control over the health service. My data suggest that the influence of the medical profession (in this case, GPs) also has a significant impact upon the implementation of 'control' measures at the local level. The implication of reform initiatives for levels of professional control would seem to be very complex. Calnan and Gabe (1991), for example, concluded that the 1990 NHS reforms served to both enhance and circumscribe professional dominance.

My analysis of the present reforms also suggests that a multifaceted restructuring of professional/state power relations is occurring. The policy outlines an increasingly formalised system of professional audit and regulation, alongside an enhanced emphasis on the role of local professionals in decision making and resource allocation. *The New*

NHS places GPs in dominant positions within the newly created institutions (PCGs) that have been given authority over resource allocation and the provision of care. At the same time, these new structures have been charged with creating and maintaining more formalised systems of professional regulation in the form of clinical governance and practice audit. GPs' mandate was extended, but on the basis that professionals become more actively involved in their own regulation.

Furthermore, Greenwood and Lachman (1996) propose that there have recently been significant ideological shifts within professional organisations. GPs have shown themselves as willing to become involved in extended managerial roles. They have become engaged in resource allocation decisions, as well as more active clinical governance regimes. In so doing, the GPs have had to incorporate both bureaucratic and managerial perspectives alongside their more traditional 'professional' outlook. Haug's (1973) 'deprofessionalisation' thesis would suggest that such shifts would in themselves result in the demise of the professions, as they undermine the foundations of the professional claim. The notion of professional 'proletarianisation' as proposed by McKinlay and Arch (1985) would go even further, suggesting that the routinisation of practice will reduce doctors to little more than the alienated position of a manual worker.

It is not, however, clear that either of these 'doomsday' scenarios have resulted from the implementation of the recent reform initiatives. These data suggest that general practice is a malleable professional group, with a power base that enables it both to adapt to changing conditions, and to minimize their negative effects. Leaving aside hypotheses

that predict that professional authority will collapse when faced with any state-imposed change initiatives, there are several competing theories as to which particular changes within the 1997 reforms might prove most challenging. Ashburner (1996) proposes that it is important that as the medical profession changes, so we carefully consider the ways in which the changes affect the underlying concepts of medical autonomy and medical dominance. It is valuable to ascertain whether the changes challenge the basis of the professional claim itself, or rather, reflect professional development. External changes are not usually met with simple rebuttal, but rather with a process of adaptation that may change the way that power or autonomy is expressed. Hence, it may be the ability to recognise challenges, and to adapt to them that is key to continued professional success.

Shortly before the release of *The New NHS*, the Chair of the General Medical Council¹¹⁸ publicly reasserted that the concept of independent professionalism rests upon the notion of self-regulation (Irvine, 1997a). The relationships of trust between both doctors and patients, and the profession and society, are key to retaining professional autonomy. Professional privilege rests on the widespread belief that autonomy and trust are warranted (Wolinsky, 1993). It is not, however, particularly evident that doctors have always fully comprehended the obligations that they must fulfil to satisfy public expectations and maintain professional status (Cruess and Cruess, 1997).

PCGs may provide GPs with a valuable opportunity to demonstrate their 'trustworthiness'. The position of trust attributed to professionals within society suggests

that incorporating professionals into service management may contribute to more successful communication with clients. Thus, the image of the system should improve once professionals (rather than either managers or politicians) are at the helm.

Furthermore, formalised regulatory structures may facilitate the demonstration of professional responsibility and reliability. The notion of doctors being able to 'cover each others back' should not be as salient in a system with identifiable accountability structures.

Just as Calnan and Gabe (1991) saw professional sovereignty as being both enhanced and circumscribed by the 1990 White Paper, so it would seem following the 1997 initiatives. Professionals were anticipating finding their clinical freedom more curtailed due to strengthened guidelines. At the same time, however, the formalised accountability structures may enhance (or at least reinforce) the trust relationships with patients that are so key to the professional claim.

Freidson (1984, 1985, 1986) challenges the notion that organisational restructurings occurring within health care systems necessarily threaten professional autonomy. At the same time, however, he proposes that the growing gulf between the majority of rank and file doctors and the elite leadership is potentially problematic. Hughes (1971) identified a trend of creating 'executives' within organisations, who are then charged with promoting the official goals and acting as propagandists. The creation of PCGs seemed to create (or

¹¹⁸ Donald Irvine is the Chair of the General Medical Council. In this position, he is responsible for the regulation of the medical profession.

enhance) a division between GPs who embraced the structural changes and those who did not.

Essentially, the PCG boards formed 'inner circles' within the profession; board members had much greater access to decision making structures and powerful information than their colleagues. In addition, they were situated to prevent any power shift from occurring. Hughes predicted that when such segregation occurs, the 'executives' become differentiated from their peers, and thus lose their status as 'full' colleagues. Although it is clear that professional differentiation occurred with the creation of PCGs, my data do not address whether this led to any loss of professional 'camaraderie' or identity for the politically active GPs in Casterdale.

7.4 Summary

Ferlie (1997) notes that there is still no consensus as to the effects of the recent changes within health care organisations for medical professions, despite considerable academic attention. While my data do not provide conclusive evidence for either the view that professionalism is completely destabilised by reform initiatives, or that professionals are able to totally undermine efforts that they perceive as problematic, I do feel that my analysis makes several valuable contributions to our existing knowledge.

Dopson (1996) states that much of the literature concerning the relationships between doctors and managers at the local level fails to set empirical findings within a theoretical framework. This lack of contextualisation is problematic because there is no

acknowledgement of the extent to which relationships are part of complex social relationships based upon differential power. I therefore set out to conduct a more theoretically informed analysis. In particular, my intention was to go beyond individual personalities and circumstances to consider both the underlying structures and the locally mediated action through which we might best understand the operationalisation of official policy.

Reform need only be meaningless if judged according to the official rhetoric

This research challenges the notion of the 'reform cycle', in which 'normalised' reform is seen to achieve little 'real' change (Meyer and Rowen, 1977; Brunnsen, 1989; Ferlie, 1997). I contend that previous research has tended to focus too closely on the extent to which official policy rhetoric matches local action. I propose that official policy is better understood as a product manufactured for particular purposes, within a political arena. On this basis, 'real' policy is made when this rhetoric is translated into workable structures by actors working within contextual constraints at the local level. Thus, although 'advances' may not appear as dramatic as the goals described in the policy documentation, this does not necessarily indicate policy 'failure'. Thus, considerations of policy are more appropriately concerned with the ways in which rhetorical propositions are integrated into existing structures, as well as how they influence such structures over time.

Reform needn't necessarily signal professional 'doom'

Greenwood and Lachman (1996) asked how professions organise, or reorganise internally to cope with contemporary changes and environmental pressures. Indeed, the question of whether structural change is damaging to professional power reverberates through much of the professions literature. There has been a tendency in sociology to reduce the complex interrelationship between professions and the state to a dichotomy of either state intervention or professional autonomy (Johnson, 1982). My data illustrate that professionals (in this case, GPs) have considerable ability and influence that allows them to mould reform initiatives. Furthermore, I suggest that a profession's ability to manipulate both the formal initiatives and their own agendas into a workable structure is key to the continuation of a powerful professional claim.

My findings concur somewhat with those of Dopson (1996), who conducted research on the effect of the introduction of the internal market to the NHS on both the role and practice of specialist doctors. She found that although the language had changed, and people were expecting real differences, essentially the system remained the same.

Clinicians who exceeded their budget were still 'bailed out', and agreements were still abandoned halfway through the year. Thus, although new cost control structures had been established (that might be expected to curtail professional practice), doctors were not forced into changing their practice. Likewise, the establishment of PCGs brought with it a language of enhanced, formalised clinical control, but little evidence of this having an impact upon daily professional practice. Previous studies of NHS reform (e.g. Elcock, 1978) have tended to find a high degree of cultural resilience and very little actual social change (Ashburner, 1996).

These data also challenge the notion that professionalism and bureaucracy need necessarily be conceptualised as oppositional. The Casterdale GPs were seemingly able to incorporate a certain level of managerial activity into their model of modern professionalism. FitzGerald (1996) is critical of sociologists' tendency to assume that professionalism and bureaucracy are necessarily in conflict, and the associated deduction that any professional move into management must necessarily be a move away from professionalism. Greenwood and Lachman (1996) also suggest that 'managerial' initiatives may be intertwined with traditional professional structures, rather than displacing them.

I propose that we should not continue to assimilate a false dichotomy of professionalism versus managerialism into our theories regarding the role of professionals within the changing welfare state. Previous work has been overly concerned with defining 'core' values of both managerialism and professionalism. It would seem more appropriate to conceptualise both of these approaches as being in flux, and to focus on the extent to which these approaches amalgamate and diverge as they develop.

Essentially, I wish to promote the notion of professionalism as an adaptable concept that is applied by a group of actors in a relatively empowered position – at least in the local setting. Becker (1970) referred to 'professionalism' as a folk concept that is available to members of a collectivity, and Dingwall (1976) argued that professionals are what we understand them to be.

Professional claims involve the incorporation of fairly elaborate accounts and props.

Reform initiatives can be understood to alter the available repertoires from which professionals can make their claims. It is, however, also the case that the state continues to depend heavily on professionals to 'carry the show'. Essentially, my data illustrate that professionals are adept at incorporating changing contexts into their sumptuous prop bag.

8. In Conclusion

My research consisted of spending eighteen months in one setting, observing the implementation of health care reform by local actors, and listening to their accounts of the process. I began this thesis by outlining how such a small piece of research, focused at the micro level, might usefully contribute to existing knowledge. I asserted that our understanding of the social world is best advanced via careful steps, building closely on what we already know. One might, therefore, expect that I would conclude by presenting a set of very focused findings and assertions whose application would be limited to a narrowly defined field.

The experience of collecting and analysing the Casterdale data did not, however, lend itself to such a construction. The complexity of the local setting and the interaction there within led me to make links between my data and various literatures. Furthermore, I chose to embrace the complexity of the object of my research, rather than to try to control for it. I feel that this decision distinguishes my analysis of reform implementation from many of its predecessors. For the purpose of reporting my analysis as clearly as possible, however, I have delineated my findings more than I would have ideally liked. I would therefore like to end by drawing together some of the ideas presented through the data, and to briefly relate both my main findings and my analysis as they pertain to various areas of research interest.

I have identified three basic 'hypotheses' that were supported by my research. I offer these not as actual scientific tenets that were tested, but rather as potentially useful heuristic concepts for presenting my understanding of the significance of my findings.

8.1 NHS reform is a key area for sociological consideration

In an increasingly 'global' society, it can be argued that change has become normalised. From the level of the individual person up to societal structures, flexibility and responsiveness to ever shifting conditions are now commonly demanded. Rather than seeing change as necessarily challenging, modifications are now often interpreted as a sign of 'healthy progress'. Thus, it is appropriate that sociologists turn attention to considerations of how such changes are incorporated into societal structures, and how they might shape those structures and associated interaction for time to come.

Health care reform has become commonplace both in Britain and internationally. Health care is one of the central tenets of the 'welfare state', and is an area of considerable public expenditure. Furthermore, the attention paid to the provision of health care by both the general public and policy makers establishes it as an area of key concern, and the frequency with which the system has been subject to reform initiatives is indicative of its significance to successive governments.

Beyond its importance for the general public and policy makers alike, NHS reform is relevant for sociological attention because of the implications of any changes for the balance of citizenship rights and responsibilities as mediated by the state. From accounts

relayed through the popular media, it would appear that health care is becoming increasingly central to notions of citizenship rights. The data from this research would suggest, however, that the state is seeking to reformulate (and seemingly, reduce) its own role and responsibility in this regard.

8.2 Professionals are commonly used to mediate state induced reforms

There is considerable evidence to suggest that with a normalisation of change comes widespread 'reform fatigue'. Against likely public opposition to yet more change, the state needs mechanisms by which it can successfully introduce and implement its ongoing reform initiatives. Professionals (general practitioners in this instance) are often engaged in this regard. Professional status provides a level of authority and trust that can be usefully incorporated into legitimisation efforts for proposed changes. Professionals are charged with having important expertise and understanding regarding appropriately meeting people's needs.

When policy proponents are successful in engaging professionals in promoting change initiatives, it can reduce the onerous task of gaining public support (or at least acceptance) for potentially disruptive upheaval. Beyond serving to facilitate the introduction of reform measures, successful professional integration may also allow the government to reduce state responsibilities.

Professional support for such measures has not, however, been particularly easy to acquire. The history of British general practice since before the introduction of the NHS reveals considerable and constant resistance to the change initiatives. Reforms have commonly been conceptualised as undermining professional claims, rather than offering opportunities for professional development. The New NHS received a critical reception, but my analysis illustrates that local GPs eventually engaged with the new structures, and incorporated the reforms into their professional agenda. Perhaps historical accounts have oversimplified previous professional responses, tending to focus analysis on initial, official responses. My analysis has rather sought to amalgamate such responses with observations of GPs' role in the implementation of the reform measures at the local level.

8.3 Health Care reform is frequently conceptualised as 'failing'

Just as I have suggested that previous analysis may have over simplified professional responses to reform initiatives, so I will also suggest that there is a tendency to misrepresent the effects of policy. Accounts have generally judged the success of policy initiatives in relation to official reform rhetoric, and have not considered the context into which such rhetoric must be placed. My research process, however, has provided the opportunity to consider how the reform rhetoric was incorporated into existing structures, and the likely effects of this incorporation for the NHS' future development.

These data suggest that change will be slow and incremental, but that the reform initiatives were largely incorporated into local action, rather than being rejected outright.

I acknowledge that powerful local actors may have been resistant to change, and that ideological positions are often difficult to shift. It would also appear, however, that local actors are often able to appreciate opportunities to pursue their own agenda through engaging with change initiatives. Where this has occurred, significant elements of the reform rhetoric have been employed.

8.4 Key Findings

I feel that one of the strengths of my research was the decision to focus on the process of localised reform implementation, particularly the translation of official ideas into local practice. Through such focus, I was able to identify various ways in which my data expand existing sociological understanding.

Through my research, I was able to consider the policy objectives as outlined through official rhetoric alongside local implementation efforts. These data often illustrated a striking incongruity between the straightforward descriptions of reform initiatives as presented in the policies, and the emergence of more complex structures as the measures were actually implemented.

I contend that the government constructed the official reform rhetoric in such a way as to avoid public and professional confrontation over cost control measures within the NHS that had proven to be so costly for previous reform measures. Official policy therefore highlighted measures to enhance clinical control, rather than cost containment. The

policy also emphasised the extent to which clinical authority will be enhanced.

Furthermore, although clinical governance measures are clearly central to this initiative, they were never clearly defined, thereby avoiding potentially problematic engagement with details. I suggest that the political context was such that such a shift was necessary to capture public support, as well as being a stronger position from which to successfully avoid alienating powerful local professionals.

My fieldwork data, however, clearly illustrated that in contrast to the official rhetoric of delegation of authority from central structures to local professionals, this was not being matched with universal application at the local level. Certain areas of work were delegated, while others were not. I propose that while the policy *rhetoric* reflects a desire on the part of the government to entice professional co-operation, the implementation process reveals government efforts to shift responsibility for areas over which they sought to reduce their own responsibility. The reform rhetoric and implementation illustrated an intriguing engagement by the government of contrasting, yet complementary notions of professional empowerment alongside the delegation of politically unsavoury tasks. The data also suggest that the government's complex agenda was facilitated by local professionals' appreciation of opportunity through such delegation – although this engagement was also couched in its own contradictory rhetoric.

In my analysis, I drew on Hughes' (1971) theory of 'dirty work' to unpack the decision making process relating to the delegation of tasks. I engage with the notion that

politically active local GPs (those who became PCG board members) largely embraced the managerial tasks being delegated to them, while at the same time constructing these tasks (particularly the idea of financially rationing care) as being 'dirty'. The GPs tended to present their involvement in the newly delegated managerial tasks as being somewhat 'martyr-like'; they took on this work in order that fellow professionals need not. I argue that this application of the idea of dirty work allowed these GPs to establish some distance from work (financial budgeting for medical care) that medical professionals usually conceptualise as being morally repugnant, while concurrently embracing this potentially advantageous work on the practical level. Furthermore, I suggest that the power of these politically engaged GPs in comparison to their colleagues was demonstrated in their ability to use these management tasks as a release from immersion in the *real* dirty work of general practice, which is the daily grind of managing repeat visits from the 'revolving door' patients with medically undefined, socially situated illnesses (Shaw and Middleton, 2002).

I argue that the GPs' engagement with the managerial tasks being delegated suggests that contrary to the professionals' rhetoric, this work was usually perceived to be more rewarding than 'dirty'. I do not, however, claim that the GPs sought a complete transfer of authority for managerial decisions from the government and local managers. Rather, GPs embraced certain tasks while seeking to retain distance from others ; they reacted differently to the delegation initiatives depending on the type of task being discussed. It would also seem that GPs sometimes appreciated advantages in being able to defer responsibility for decision making to a 'higher authority'.

Furthermore, the role played by local managers during this process would suggest that they also grasped this as an opportunity to use existing authority structures to further entrench their own continued influence. Managerial rhetoric emphasised the unattractiveness of many of the managerial tasks – particularly for the overburdened and underexperienced GPs. Thus, managers also engaged with the idea of constructing work as ‘dirty’ – although in this instance it was to ‘shield’ such tasks as dirty from a potentially more powerful group (GPs).

This complex engagement with delegated tasks on the part of local actors (both the GPs and managers) seemed to facilitate the implementation of a potentially very controversial set of policy reforms. Local actors did not seem to perceive deviation from the official policy position during the implementation period as particularly problematic. Rather, each group sought to engage with the official objectives at a level that was beneficial to their own agenda, while also carefully constructing ‘dirty work’ rhetorics as a way of avoiding the appearance of self-serving engagement in the process.

The sociological literature outlines an expectation of high levels of confrontation between professionals and the state (largely represented by managerial staff at the local level) during periods of change. In contrast, these data strongly suggest that local implementation was largely defined by active efforts on the part of both managers and professionals to maintain co-operation and consensus, and to strengthen existing relationships. Local actors may have recognised that they stood to lose if co-operation

were to break down, and therefore worked hard to avoid conflict that would necessitate absolute resolution (thus differentiating a clear ‘winner’ and ‘loser’). More attention to ‘network’ models of organisations might be beneficial to further considerations of such reform initiatives.

Finally, my research disputes the notion that health care reform is simply cyclical and procedural, leading to no ‘real’ change. I contend that ‘posthumous’ analyses that compare outcome measures to official reform rhetoric suffer from a misunderstanding of the policy implementation process. Indeed, even though the 1997 reforms were superseded by further measures (in 2000 and 2001) outlined to address their shortfalls, the data suggest that they led to some incremental change at the local level regarding the ideological context of health care provision. The notion of collaboration, rather than competition survived, as did the idea of locally based professional collaboratives influencing resource allocation. There has also been a seemingly an abiding shift in the ideological framework around clinical governance, with more attention being paid to professional ‘accountability’, and a greater focus on addressing the needs of the collective population, rather than the individual patient.

These data would suggest that a continued consideration of reform initiatives is valuable. It is essential that local implementation is not assessed according to impossible rhetorical positions as laid out in politically motivated policy documents. Rather, on-going research into policy implementation should consider the relative influence of various local actors in the context of existing structures. Such research will be valuable for understanding the

long-term development of the ideological constructs that shape the policy realm. In essence, understanding the relationship between the professions and the state is largely a question of who is most able to promote their agenda, and how?

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Appendix 3i

4 August 1998

Dear Dr 'Jones',

I am writing to let you know that (The Commissioning Co-ordinator) has arranged for me to observe the Programme Two meeting on Monday, August 4th. He has arranged this as I am interested in understanding the involvement of GPs in all levels of the commissioning process. I have the impression that the nature of GPs' involvement in such meetings is quite unique to Casterdale, and thus it holds some significance for a better understanding of the commissioning process and the grounding for PCGs in this area.

I wanted you to be aware that I will be observing the meeting. Please contact me if you have any questions or reservations about this. My work number is (0115) 9515410 and my home number is (0115) 9515339.

I look forward to seeing you on Monday.

Yours sincerely,

Kate Clegg

School of Sociology and Social Policy

University of Nottingham

University Park

Nottingham

NG7 2RD

Appendix 3ii

January 13, 1999

Dear Dr. 'Jones',

My observations at the Commissioning Forum over the last few months have been extremely valuable for my work on the changing role played by general practitioners within the NHS. The discussion has raised numerous questions that I am keen to follow up, in order to gain a more accurate image of GP involvement in commissioning, especially in anticipation of the launch of PCGs in April.

I would like to contemplate how GPs' role might be changing with the end of the Commissioning Pilot, and the start of collaborative commissioning on behalf on PCGs. Additionally, I am keen to learn more about the work that is done at the programme level.

I am therefore writing to ask whether you would be willing to discuss your role in commissioning with me. I am aware of the tremendous pressures on your time but I feel that your input could be of great benefit to my consideration of this issue. The interviews that I have conducted so far have tended to take about 45 minutes.

I will telephone your surgery in the next week to try to arrange an appointment, but if you wish to contact me in the meantime I can be reached at the above address, by telephone (0115 9515338) or by e-mail (lqx6kc@lzn2.lass.nottingham.ac.uk).

I look forward to speaking to you.

Yours sincerely,

Kate Clegg

Appendix 3iii

The organisational structure within Casterdale when I began my fieldwork was as follows:

Historical Background:

The Conservative Government had established an 'internal market' within the NHS in 1990, following the release of the White Paper, *Working for Patients* (1989). The internal market was based upon the principles of competition and greater efficiency through the separation of providers and purchasers of care. The role of 'providing' secondary services was removed from health authorities (whose role became overseeing the purchasing of care), and given to hospitals. In turn, the hospitals developed into independent entities known as self-governing Trusts from whom the health authority would purchase care on behalf of their population.

New purchasers were also introduced to the internal market alongside health authorities. GP partnerships of a certain size (which was progressively reduced over time), were given the option of directly purchasing a limited amount of services on behalf of their own patients. They would become somewhat independent of the health authority; they would be responsible for maintaining their own budget in regards to these services. GPs who chose to take on such additional purchasing roles became known as 'fundholders'. Fundholding created a division within the current system of purchasing. Fundholding

GPs negotiated contracts directly with Trusts and purchased care for their own patients, whereas health authorities continued to do this work for non-fundholding GPs.

Fundholding was a voluntary scheme, and was not uniformly taken up by all GPs around the country. Casterdale was one area with a high level of GP opposition to fundholding, and a very low percentage (relative to the rest of the country) of local GPs became fundholders.

Purchasing becomes Commissioning:

The notions of an internal market and ‘purchasing’ care as were established in the NHS of the early 1990s were fairly problematic (see chapter 2). The internal market created unpopular inequalities within the system, and was only partially effective due to a general unwillingness to let true competition take its course (with inevitable winners and losers among providers). Furthermore, the notion of ‘purchasing’ was criticised because of the amount of ‘wasteful’ bureaucracy that it entailed. ‘Commissioning’ was one idea to develop out of these critiques of fundholding. Commissioning softened the idea of purchasing, and was based upon the idea of collaboration between purchasers and providers, rather than competition.

A group of Casterdale GPs became engaged with the idea of commissioning and developed an alternative means to fundholding that would allow GPs to be involved in attaining care for patients. Their idea of ‘Collaborative Commissioning’ was supported

locally by the Casterdale Health Authority, as well as on the national level by the Labour Party (who were then in opposition).

By this point (mid 1990s), the Conservative Government had also begun to question whether fundholding would deliver what they had hoped in terms of purchaser driven quality and efficiency. They had started to investigate possible alternatives systems, and thus supported a set of 'pilot' commissioning schemes around the country. Casterdale established such a pilot in the form of the Total Commissioning Group/Project¹¹⁹ (TCG). Casterdale's commissioning pilot was given limited control over its own budget (within the bounds of the health authority), and an incentive scheme was established whereby if the TCG reduced prescribing levels to close to the budgeted level GP practices participating in the scheme would receive additional resources for local allocation.

The vast majority of local GPs joined the TCG. Some (although not all) fundholding GPs chose not to join the TCG. There was also a small group of GPs who were involved in a different organisational pilot (which was abandoned with the announcement of PCGs and will not be further discussed in this thesis).

Sixteen GPs from local practices were elected to act as advisory 'forum members' for the TCG, and to represent the views of GPs within the new structure. Four members of the Forum were then elected to sit on a 'Pilot/Project Board' to make commissioning decisions. One of the four project board members was elected as the chair of the

¹¹⁹ It became 'Project' from 'Pilot' once the pilot period had finished.

Pilot/Project. The sixteen TCG Forum GPs represented GPs on the Health Authority's commissioning working groups that were known as 'Programmes of Care'. This was the first time that GP representation on such committees had been formalised in Casterdale.

Resource allocation (purchasing or commissioning) had been subdivided into 'streams' or 'programmes' by the Health Authority, and GPs had been included (on an informal basis) since before the introduction of commissioning.

Programmes of Care:

There were four recognised target areas:

- 1. Children, women and sexual health*
- 2. Surgery and A&E*
- 3. Aging and disability*
- 4. Mental Health*

Appendix 3iv

By April 1999, the organisational structure of Casterdale Health Authority was as follows:

During the fieldwork period, there was considerable government input into the provision of care in Casterdale through the White Paper (*The New NHS*), and subsequent central guidance and directives. These had an impact on the structure of the Health Authority itself: many of the Health Authority's roles were redirected to PCGs, and it acquired new work with the preparation for and implementation of the new structures.

The implementation of *The New NHS* established several PCGs with populations of about 100,000 throughout Casterdale. Each of these had boards had maximum GP representation (seven out of eleven members). Several of the PCGs were still to establish a formal communication structure between the 'ordinary' members of the PCGs (clinicians working with the population) and board members. The Casterdale PCGs were all designated 'Level Two' status. This means that they shared budgetary responsibility with the health authority.

Members of Casterdale PCGs made the decision to collaborate in many areas, and to create small 'superstructures' that would link the PCGs. A PCG Chair committee, a clinical governance committee, and a collaborative commissioning board (CCB) were all formed. There was a representative from each of the PCGs on each of these committees.

In addition, a Collaborative Commissioning Mechanism (CCM) was established with the role of informing the CCB's decisions. This structure had three clinical (though not necessarily GP) representatives from each PCG.

During the first month of their existence, the PCGs agreed (with strong support from the Health Authority) that they would commission services collaboratively. The CCM and the CCB would have responsibility for deciding how to allocate resources. In reality, these decisions were greatly restricted by the need to support the secondary sector, as well as political considerations. The power of the secondary sector to shape resource allocation decisions was largely unknown at this time.

'The Programmes of Care' had been the committee structure for making secondary care commissioning decisions before the advent of PCGs. These committees had memberships that included members of the Health Authority, and representatives from the TCG, secondary care, and social services. The creation of PCGs and the HIMP made these committees fairly redundant, but no replacement 'cross-sectional' collaborative structure had yet been established.

The Health Improvement Programme (HIMP) was also becoming influential at the local level. The HIMP is a centrally derived initiative with the objective of creating standardised priorities across the NHS. That HIMP was supposed to develop into a structure that would shape all local and national health care provision. National targets (such as cancer, heart disease and accidents) had already been formulated, and

over time local targets would also be incorporated. Local targets were therefore being developed in relation to the identified priorities. There was a Health Authority team working on developing the HIMP and integrating it with local structures.

Communication between the Health Authority team and the PCGs over the HIMP were developing.

By the end of the fieldwork, Casterdale had been named as a second wave Health Action Zone (HAZ). This was also a centrally driven initiative. However, unlike the HIMP, the HAZ initiative brought considerable additional resources to the area. The aim of the HAZ initiative was to reduce health inequalities by focusing resources into the most economically deprived areas. The HAZ would provide 'seed' funding for seven years that was supposed to fund projects that were able to demonstrate effectiveness in reducing health inequalities. Some of the HAZ money was retained by the Health Authority to allocate to projects across the district, and some was distributed to the PCGs, depending on their estimated level of economic deprivation and need. Several of the Casterdale PCGs were considered to be substantially economically deprived. These PCGs received the majority of the money allocated locally. The other PCGs were all given some additional funds, but in much smaller amounts.

The HAZ project had a Co-ordinator within the Health Authority. The Co-ordinator was active in explaining the HAZ and the related resources to members of the PCGs during the fieldwork period. The relationship between the PCGs and the HAZ had, however, not yet been fully determined by the end of my fieldwork.

Appendix 3v

The Key Actors in Casterdale

(These are my own working definitions. They reflect only how I interpreted people's role rather than any 'official' position.)

Health Authority Chief Executive is responsible for the overall management of the health authority. He oversees all of the work done through the health authority, including the implementation of *The New NHS*. He is appointed by and accountable to the Government. He is a manager, rather than a clinician.

Health Authority Chair is a clinical post. He is appointed by the Government. The Chair acts as somewhat of a balance to the Health Authority Chief Executive. He is the principal member of the Health Authority Non-Executive board. He is responsible for 'guiding' the health authority, but is less involved in the day-to-day management of the organisation. There is a significant political and ceremonial element to the role. He is also responsible for chairing health authority board meetings (the ultimate accountability structure at this level). The agenda of these meetings seems, however, to be largely dominated by Health Authority Executive (managerial) items.

Health Authority Director of Commissioning is an Executive (highest managerial level) position. The Director of Commissioning is a manager, not a clinician. He reports

to the Health Authority Chief Executive, and is responsible for all work/spending in relation to commissioning (used to be purchasing). This is a very influential post. [The holder of this post resigned during the fieldwork period and it was held by an 'Acting Director' (the Commissioning Co-ordinator) for the duration of my fieldwork].

Health Authority Commissioning Co-ordinator is a high/middle management position. He reports to the Director of Commissioning and is responsible for the day-to day management of all commissioning work. The commissioning work was divided into several different teams (the structure of which seemed always to be changing). This individual seemed to have considerable control within the health authority and autonomy in relation to running the commissioning teams.

Project Manager of the Total Commissioning Group was a temporary, seconded position. It was a middle management job. He oversaw the implementation of the TCG and the subsequent Collaborative Commissioning structures, and facilitated the work being done by within these arenas. The TCG project manager became the managerial 'expert' around commissioning and GP involvement. This work made them central to the preparation for PCGs. He formulated the original PCG constitutions and oversaw the elections to the PCG boards. The job was dissolved after PCG shadow boards were in place.

Primary Care Group Project Managers were temporary middle management secondments from commissioning teams with the role of managing the introduction of

PCGs. There were two PCG project managers working alongside during the fieldwork period. They worked closely with the TCG project manager and the Commissioning Co-ordinator.

Public Health Consultant was a GP who had trained for an additional five years (later on in their career) to become a specialist in public health. He was employed by the Public Health department within the health authority. He sat on commissioning committees and one of the new PCG boards.

PCG Implementation Officers were temporary, seconded, middle management positions. Several of the posts were taken either by ex-fundholding managers (whose jobs were being dissolved) or by members of the commissioning teams (whose jobs were also being 'fed out' to PCGs). Their role was to support the PCGs during the shadow period until PCG chief executives could be put in place. Only one of the implementation officers was given the permanent position of PCG Chief Executive (though several applied).

Health Action Zone Co-ordinator was a middle/high managerial position with considerable influence. The holder of this position had been instrumental in securing the status and funding for Casterdale as a Health Action Zone. He would oversee the seven year project, including the allocation of additional resources and working with the PCGs.

PCG Chair is an elected, clinical position. He is responsible for leading a PCG, and is responsible for its 'direction'. He chairs the PCG board, and is in close contact with the

health authority and other PCGs. He oversees all commissioning and clinical governance work of the PCG, although there are also others allocated to manage these tasks.

PCG Chief Executive is an appointed, managerial position. He will work with the PCG Chair to manage the PCG. He will have responsibility for communication between the health authority and the PCG. He will manage the PCG on a daily basis, including overseeing PCG staff.

Appendix 3vi

Initial ‘categorisation’ of the data: the first coding framework

GP Autonomy

- Salaried practice and Independent contractor status
- Collegial control – clinical governance
- Linked budgets
- Different types of autonomy – economic, political and clinical.
- Group control v. individual control
- Role of the LMC
- Governance of PCGs
- Collaborative working
- Clinical governance
- Rationing
- Decision making structures
- Standard setting/keeping in general practice
- PACT/RACT data
- Leadership
- Workload
- Clinical guidelines

- Equity
- Evaluation
- Incentive schemes
- Peer review
- Professional comparison
- Sharing information
- GP/PCG 'ownership'
- Expertise
- PCGs as distinct – opposite of collaborative?
- Patient advocacy
- Professional hierarchy

GP reactions

- GP resistance/involvement
- Disillusionment
- Role of a GP

State/Professional Control

- National guidance
- Local restrictions
- Knowledge of procedures
- 'The shadow period'
- Local needs assessment

- Clinical governance
- Rationing
- Accountability
- Decision making structures
- Timescale of change
- Delegation of responsibilities
- Risk management
- Standard setting/keeping in general practice
- PCG ownership
- Relative roles/responsibilities of the HA and PCGs
- Relationship between HA and GPs
- Centralised control
- Clinical guidelines
- Clinical effectiveness
- Health Authority 'heavy handedness'
- Transition to PCGs
- PCG power
- Accountability framework/line of authority
- Divide and rule
- National initiatives/targets
- Local initiatives
- Saving money
- Peer control

- Managed care
- Information delay from the centre

Process of Change

- National guidance
- ‘The shadow period’
- Decision making structures
- Progression towards Trust status
- Timescale of change
- Communication between GPs/PCG members
- Transition from TCG to PCG
- Formation of PCGs
- Goals of change: waiting lists, efficiency, HIMP, HAZ, quality, Organisational culture
- Non-goal work: team building, group maintenance
- ‘roles’ in the new structure
- GP representation
- Changing culture

‘Free Nodes’

- Data
- Assessment of health needs
- Inequality – redistribution

- 'Dirty work' for general practice
- Information sharing
- Cross professional working
- Relationship with Trusts
- Fundholding
- Prioritising of primary care
- Resources
- Agenda items
- Doctor/patient relationship
- Stakeholders

Clinical Issues

- Prescribing
- Physiotherapy
- Viagra
- Alternative medicine
- Counselling
- Ophthalmology
- A&E
- Cytology smears
- Nursing homes

From the Literature:

Organisations literature

Rules and Structure

- Formation of new 'rules'
- Breaking or ignoring 'official' rules
- Creation of 'unofficial' rules
- Evaluation and Inspection
- 'Negotiation'

Culture

- Myths and legends
- Expression of 'values'
- Conflict
- The 'taken for granted'

Goals

- The idea of 'reform'
- The definition of problems and goals that drive change
- Who sets goals?
- Who controls change?
- Non-goal work – team building and group maintenance
- Intentions of work

- Actual activity/work being undertaken
- Pronouncement of official goals
- Operative/daily goals
- Goal displacement – when the process of attaining the goal becomes more important than the goal itself. Original goal abandoned.
- Disparity between official goals and stakeholder goals

Change

- Change as norm or traumatic: recurrent change – homeostasis
- Negotiation of the change process between ‘managers’ and stakeholders
- Attempts to change culture
- Change as a means by which to keep people focused on the future.

Professions Literature

The ‘claim’ to professionalism

- Choice
- Autonomy
- Satisfaction
- ‘Cultural authority’ (the ability to define the experiences and needs of clients)
- ‘Formalisation’ of review procedures

The role of the state

- Mediator between professionals and clients
- Monopolistic purchaser

Changing nature of professionalism

- Professional hierarchies
- Bureaucracy

Appendix 3vii

Q.S.R. NUD.IST Power version, revision 4.0.

Licensee: Kate Clegg.

PROJECT: PhD, User Kate Clegg, 11:17 am, Sept 23, 1999.

(1)	/Negotiation
(1 1)	/Negotiation/Cultural change
(1 2)	/Negotiation/Clinical governance
(1 3)	/Negotiation/Collegial control
(1 4)	/Negotiation/Commissioning
(1 5)	/Negotiation/Local focus
(1 6)	/Negotiation/Inequalities
(1 7)	/Negotiation/Evolutionary change
(1 8)	/Negotiation/Agenda
(1 9)	/Negotiation/Role of the Health authority
(1 10)	/Negotiation/Fundholding
(1 11)	/Negotiation/accountability
(1 12)	/Negotiation/National initiatives
(2)	/Control
(2 1)	/Control/Decentralisation

(2 1 1)	/Control/Decentralisation/Local
focus	
(2 1 2)	/Control/Decentralisation/National
initiatives	
(2 1 3)	/Control/Decentralisation/Timescale
of change	
(2 1 4)	/Control/Decentralisation/Central
guidance	
(2 1 5)	/Control/Decentralisation/PCG
Collaboration	
(2 1 6)	/Control/Decentralisation/Local
initiatives	
(2 1 7)	
/Control/Decentralisation/Commissioning	
(2 1 8)	/Control/Decentralisation/GPs as
agents of the state	
(2 1 9)	/Control/Decentralisation/Progress
to PCTs	
(2 1 10)	
/Control/Decentralisation/Collaborative commissioning	
(2 1 11)	/Control/Decentralisation/GP
involvement	
(2 1 12)	/Control/Decentralisation/Rationing
(2 1 13)	/Control/Decentralisation/Workload

(2 1 14)	/Control/Decentralisation/Expertise
(2 2)	/Control/Control over practice
(2 2 1)	/Control/Control over practice/Inequalities
(2 2 2)	/Control/Control over practice/Collegial control
(2 2 3)	/Control/Control over practice/Clinical governance
(2 2 4)	/Control/Control over practice/Efficiency
(2 2 5)	/Control/Control over practice/Autonomy
(2 3)	/Control/Agenda
(2 4)	/Control/Accountability
(2 5)	/Control/Role of the Health authority
(2 6)	/Control/Evolutionary change
(2 7)	/Control/Cost control
(2 8)	/Control/Authority
(2 9)	/Control/Assessment or evidence
(2 10)	/Control/Workload
(2 11)	/Control/Quality
(2 12)	/Control/Information
(2 13)	/Control/Resources

(2 14)	/Control/culture change
(2 15)	/Control/Targets
(3)	/Professional agenda
(3 1)	/Professional agenda/Cultural
change	
(3 2)	/Professional agenda/Agenda
(3 3)	/Professional agenda/Inequalities
(3 4)	/Professional agenda/GP involvement
(3 5)	/Professional agenda/GP reluctance
(3 6)	/Professional agenda/Collegiality
(3 7)	/Professional agenda/Boundaries
(3 8)	/Professional agenda/Autonomy
(3 9)	/Professional agenda/Commissioning
(3 10)	/Professional agenda/GP Role
(3 11)	/Professional agenda/Clinical
governance	
(3 12)	/Professional agenda/Accountability
(3 13)	/Professional agenda/Workload
(3 14)	/Professional agenda/Hierarchy
(3 15)	/Professional agenda/Professional
communication	
(3 16)	/Professional agenda/Remuneration
(D)	//Document Annotations
(F)	//Free Nodes

(F 1) //Free Nodes/Formation of PCGs
(F 2) //Free Nodes/Communication
(F 3) //Free Nodes/Patient's role and
responsibility
(T) //Text Searches
(I) //Index Searches
(C) //Node Clipboard - 'Professional
agenda'

