Systems and Organisations

Public management 'reform' narratives and the changing organisation of primary care

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Key messages

The prime audience of general and clinical managers in primary healthcare and primary care trust (PCT) board members should consider the following questions:

- 1 Does the new government have a coherent and enduring narrative of public services reforming? If so, what are the implications for the primary care organisations?
- 2 What are the most important organisational ideas currently evident in the primary care field nationally, regionally and locally?
- 3 Is there a shift back to New Public Management (NPM) governance?
- 4 What implications do any such ideas have for major organisational change in my local PCT?

Why this matters to me?

I work in an academic department of management in the field of public management and organisational studies. I have always been interested in the way in which healthcare politics affect the changing organisation of health services. The pace of public policy reforming has accelerated so that academically there are now more healthcare reorganisations to study! Such macro reorganisations relate to general narratives of public management reform, such as a preference for quasi market or network-based approaches. Such changes are best studied over the long run and retrospectively when broader trends become apparent.

ABSTRACT

This paper explores how different models of public management affect the changing organisation of primary care. It examines important non-clinical drivers of major organisational change. It uses the concept of a 'reform narrative' to connect public management reform ideas, political doctrines and their effects on primary care organisations. It outlines a set of possible models of public management

and their application with primary care settings. It explores what might be the dominant reform ideas of the next decade.

Keywords: healthcare politics, organisational change, primary care organisations, public management reforming

Introduction

This article examines changing forms of organisation in primary care as seen from an organisational studies perspective. It traces how general ideas of public management reform affects primary care organisations, as other public services. Examples are the restructuring of PCT boards; the introduction, removal and now possibly reinstatement of GP fundholding; patient feedback or audit systems and new systems of clinical

governance, quality and safety. Where do ideas for such organisational changes come from? How are they articulated within the public policy system?

The focus is deliberately macro level and organisational: the paper analyses the non-clinical drivers of major change. Such changes are connected with general narratives of public management 'reforming'. The word 'reforming' is in inverted commas as it is not

seen as necessarily beneficial (this judgement would require *post facto* empirical evidence that is rarely available). Rather, the term acts as a rhetorical device to mobilise political and organisational action. The concept of a 'reform narrative' emplaces specific reforms in their broader context. A reform narrative consists of implicit and explicit high-level theories about how public services should be organised, including normative as well as empirical argumentation (for example, is patient choice more important than less health inequality or vice versa?) and connected policy prescriptions.

It is furthermore assumed that primary care shows the general reform trends found in other public service organisations, possibly with a lag. For example, general managerial roles were introduced in hospitals in 1985; in primary care in 1990, therefore analyses which are primary care specific miss the bigger picture of public policy reforming. In this sense, primary care is more similar to other public services organisations than dissimilar. Thirdly, the paper assumes an era of 'hyper reforming',¹ given the expanded political ambition to secure public services reform exhibited by successive recent governments. In the publicly funded and centralised NHS, politicians have important power resources to restructure public services. The political world emphasises 'change' (rather than continuity) as a master slogan, even if the content of change is often unclear. Public services are to be 'modernised', with established interest and producer groups (such as clinicians) coming under scrutiny and even suspicion.

The paper will now outline different narratives of public management, presented in a simple temporal sequence, exploring their effects for primary care organisations. These models are pure types which help induce concepts and actual, existing, primary care organisations may show a mix of such models.

1948–1990: Professional dominance and professionalised bureaucracy

This classic account sees healthcare organisations as dominated by strong professions, especially medicine,² rather than by line management or by sovereign consumers. Autonomy is given by the State to medical professionals in exchange for the promise of responsible and ethical behaviour. Related occupations (such as nursing) engage in profession building, seeking to emulate medicine. The result is a system of professions³ which bargains internally for jurisdictions and control over tasks (what does a doctor do and what does a nurse do? And who decides?).

These dominant professionals are located organisationally within a professional bureaucracy⁴ rather than a standard line managed organisation. Administration is here facilitative rather than directive, implementing rules, regulations and payment practices drawn up after consultation with professionals. Real strategy emerges informally from the clinical field through incremental proposals for service growth which then move upwards. While senior professionals (e.g. GP Partners) value 'collegiality', there are marked power inequalities between them and the rest of the healthcare workforce. This pattern characterised the old Family Practitioner Committees (FPCs) between 1948 and 1990, which displayed a facilitative and rule bound form of administration (rather than 'management') that in practice had few levers to influence clinical behaviour. Payment systems were codified in a set of regulations. The self-employed general practitioner status and the partnership based mode of organisation in practices made direct managerial control problematic. There was little active scrutiny of professional practice, including poor performers. High-profile scandals (e.g. Shipman Enquiry) painted a picture of failing systems of self-regulation: difficult or even dangerous colleagues were not being dealt with. The promise by the profession to the State of responsible self-regulation had not been fulfilled.

1990–1997: New public management: management, measurement and markets

The 1980s and 1990s saw the global rise of New Public Management (NPM) ideas,⁵ based on ideas from organisational economics. They were sponsored politically by radical right governments and Ministries of Finance to challenge spending ministries (such as Health). Suspicious of professional dominance, the NPM reform narrative emphasised '3 Ms' as guiding principles of reform: (i) management (ii) measurement of performance and (iii) markets or quasi markets. NPM's dominant values stressed efficiency, performance and transparency rather than collegiality or democratic accountability.

Within the NHS, new general management roles were brought in hospitals in the mid 1980s and then in primary care in 1990, replacing the old administrators. The old FPCs were replaced in 1990 by smaller, more corporate Family Health Services Authorities with fewer professional members and more non-executives from private business. A managerial core emerged in primary care. Quasi markets included GP fundholders to act as entrepreneurial 'micro purchasers',

complementing District Health Authority 'macro purchasers'. Patient voice was orchestrated through market research and patient satisfaction surveys. Contracts and incentives were used to influence GPs to hit explicit performance targets. NPM reforms took a long time to implement and faced professional resistance. For a long period, primary care organisations combined commissioner and provider roles and only recently were community health services spun out into a separate trust. While subsequent reform cycles reacted against the excesses of the NPM, some of its key ideas (e.g. performance measurement and management) remained embedded and resilient.

1997–2010: Network governance reforms: from quasi market to managed network

Critics of NPM⁶ stressed their dysfunctional aspects: strong vertical reporting lines led to a silo mentality and poor lateral working; a concentration on finance and activity marginalised quality; a democratic deficit and managerial excesses eroded civic and professional engagement. Writers developed post-NPM accounts which did not repudiate all NPM – valuing and even intensifying strong performance management – but which balanced NPM with softer ideas.⁷ Newman⁶ describes the post NPM network governance narrative. There was a broader range of actors in the policy process: which was not located solely in Whitehall but increasingly involved 'strong regions' (Scotland, Wales and to a lesser extent London) downwards and moved upwards to the EU. There were more partnerships with the private sector including the significant Private Finance Initiative. There were more cross sector partnerships such as Health Action Zones.

Health policy shifted after 1997 away from GP fundholding (absorbed by the new primary care groups, then trusts) towards collaboration and continuity of care. Lateral working was supported by managed networks involving primary care (e.g. Older People's networks; Managed Cancer Networks) and other agencies.⁸ Such networks were not of the informal and professionally dominated character suggested by professional dominance but explicitly 'managed' with a managerial core (e.g. Network Director), responsible for meeting national targets. They had neither line management authority nor control over finance but had to win local influence instead. After 2000, the partial and confusing move back to choice and quasi markets (e.g. London Patient Choice Project) and away from integrated care perhaps reflected political disillusion with the slow pace of change in networks.

Late 1990s onwards: Governmentality: clinical governance, quality and safety

From the late 1990s, a novel health policy agenda based on clinical governance, quality and safety has been developing. Such ideas seek to reform clinical behaviour through a mix of surveillance, self-surveillance and self-development techniques (e.g. appraisals, critical incident reports, performance indicators, league tables). There is an emphasis on visibility and transparency. This approach does not fit the professional dominance, NPM or Network Governance models so how should we understand it?

The work of Foucault, the French philosopher, has been used by various authors (for example Waring)⁹ to explain such developments. Foucault studied the rise of the hospital, prison and asylum in France as new organisational forms around 1800.^{10,11} Foucauldian concepts of power and rule distinctively refer to an ensemble of surveillance (now electronic as much as physical, as new information communication technologies (ICTs) increase the ability of the centre to survey the clinical field) and self surveillance regimes. New institutional sites (e.g. National Institute for Health Research (NIHR); National Institute for Clinical Excellence (NICE) produce bodies of knowledge and associated techniques (e.g. the evidence-based medicine (EBM) movement and its guidelines) which diffuse across the clinical field. Control over such 'discourse' represents an important source of power (power/knowledge) rather than direct command. A core Foucauldian concept is 'governmentality' or ability to shape conduct through subtle and legitimate means. Flynn¹² analysed the NHS clinical governance regimes in a governmentality perspective where audit was linked in to regulation and accomplished through new forms of self-surveillance.

Applications of this perspective in UK primary care include Sheaff *et al*'s¹³ analysis of new clinical governance systems which might mark a shift away from old professional dominance. The new EBM/clinical governance discourse and associated guidelines presented itself in primary care as soundly evidence based. So non-compliance would be both clinically and scientifically impossible. Clinical governance was operationalised through semi-formal networks rather than contracts or hierarchies. At the heart of these networks lay a clinical/managerial core extending its surveillance over the primary care field. The old exception management was yielding to a continual and mainstream scrutiny of primary care doctors, using routine, comparative/directive data such as practice level performance indicators.

Conclusion: The post 2010 era: new localism? Or back to treasury led NPM?

The 1997–2010 period of buoyant funding of health-care has now finished, although it is as yet unclear what overall trajectory of public management reforming will follow it. The Conservative idea of 'New Localism' is a candidate narrative, reacting against what in practice became the target-led and top-down nature of New Labour governance of the NHS (although earlier Network Governance ideas were looser and more collaborative). For primary care, this New Localist idea suggests a greater provider role for non-profit organisations, more localised decision making and resource allocation. It suggests more democratic representation on PCT boards and a swing from PCT-led macro purchasing to GP fundholding (GPFH) micro purchasing.

But will such New Localist ideas develop into a long-term reform narrative, with the programmatic qualities needed to endure? Public management reform ideas can be here today but gone tomorrow, such as the brief flowering of stakeholder theory around 1997 which quickly disappeared. 'New Localism' may well fail to generate an enduring programmatic quality. Given the deep financial reductions likely across public services including primary care, the most likely scenario is surely that NPM re-emerges as a master narrative, once more sponsored by a powerful Treasury against spending departments. It remained resilient and embedded even in the 1997–2010 period and has now been revived by the crisis in public debt.

The containment and reduction of public expenditure here becomes a strategic policy objective across all public services, including primary care. This Treasury/NPM led scenario implies a move back to such policy instruments as strong financial controls, senior general management, performance management, quasi markets, and the use of strong (dis)incentives/contracts to influence clinical behaviour and in particular to penalise over-spenders and over-referrers. Other implications include more market entry by private providers and higher charges for wealthier consumers as quasi markets begin to take off. PCTs take on the 'pure' role of commissioner, financial controller and market maker. The policy focus shifts back to financial control and activity rather than quality or safety. Networks and system level working give way to a hierarchy/quasi market/contracts mix. PCT non-executives are appointed for financial expertise rather than as community representatives. Clinical managerial 'hybrids' find an increasingly financially driven agenda personally distasteful, give up their managerial roles and revert to their original role as clinicians,

causing problems of legitimacy for PCTs in the management of GPs.

So it will be interesting to chart how the new Conservative–Liberal coalition develops its strategic ideas for reform in the public services, including primary care and whether the prediction here of a turn back to NPM-based governance – with all that implies – comes true.

ETHICAL APPROVAL

None required.

CONFLICTS OF INTEREST

None.

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