

Contents

<i>List of Figures, Tables and Boxes</i>	vii
<i>Preface</i>	viii
<i>Notes on Contributors</i>	ix
<i>Acknowledgements</i>	xxii
<i>Introduction</i>	xxiii
1 Medicine and Management in English Primary Care: A Shifting Balance of Power? <i>Rod Sheaff</i>	1
2 Processes of Change in the Reconfiguration of Hospital Services: The Role of Stakeholder Involvement <i>Naomi Fulop, Perri 6 and Peter Spurgeon</i>	19
3 Hospital Sector Organisational Restructuring: Evidence of Its Futility <i>Jeffrey Braithwaite, Mary T. Westbrook, Donald Hindle and Rick A. Iedema</i>	33
4 Decentralization as a Means to Reorganize Health-Care in England: From Theory to Practice? <i>Mark Exworthy and Ian Greener</i>	46
5 Va Va Voom, Size Doesn't Matter: Form and Function in the NHS <i>Jill Schofield, Rod Sheaff, Russell Mannion, Bernard Dowling, Martin Marshall and Rosalind McNally</i>	59
6 Evidence-Based Management: The Power of Evidence or Evidence of Power? <i>Mark Learmonth</i>	75
7 'Speaking Truth to Power': On the Discomforts of Researching the Contemporary Policy Process <i>David J. Hunter</i>	87

8	It's Part of the Job: Healthcare Restructuring and the Health and Safety of Nursing Aides	99
	<i>Michael J. O'Sullivan, C. Eduardo Siqueira, Kathy Sperrazza, Ainat Koren, Karen Devereaux Melillo, Lee Ann Hoff, Edna M. White-O'Sullivan and Craig Slatin</i>	
9	Chasing Chameleons, Chimeras and Caterpillars: Evaluating an Organizational Innovation in the National Health Service	112
	<i>Catherine Pope, Andrée le May and John Gabbay</i>	
10	Engaging the Public Voice in Health Care Decision-Making	123
	<i>Ann Casebeer, Gail MacKean, Julia Abelson, Bretta Maloff, Richard Musto and Pierre-Gerlier Forest</i>	
11	The Swampy Lowland: Using Hyperlinks to Navigate the Multiple Realities of Partnership	139
	<i>Marion Macalpine and Sheila Marsh</i>	
12	Systems Thinking for Knowledge Integration: New Models for Policy-Research Collaboration	154
	<i>Allan Best, William K. Trochim, Jeannie Haggerty, Gregg Moor and Cameron D. Norman</i>	
13	Strategies of Persuasion: The Efforts of Nurse Practitioners in Institutionalizing a New Role	167
	<i>Trish Reay and Karen Golden-Biddle</i>	
14	Knowledge to Action? The Implications for Policy and Practice of Research on Innovation Processes	180
	<i>Louise Fitzgerald, Sue Dopson, Ewan Ferlie and Louise Locock</i>	
15	Is the Best Defense a Good Offense? Marketing of Quality by US Nursing Homes	194
	<i>Jane Banaszak-Holl, Judith G. Calhoun and Larry R. Hearld</i>	
16	Models of Medical Work Control: A Theory Elaboration from English General Practice	209
	<i>Martin Kitchener and Mark Exworthy</i>	
	<i>Author Index</i>	224
	<i>Subject Index</i>	230

1

Medicine and Management in English Primary Care: A Shifting Balance of Power?

Rod Sheaff

Policy re-cycling and organizational power

How power is distributed between managers and care professionals is a central question in social policy. Since 1990 English NHS primary care has had three main 'reforms' of organizational and governance structures and many smaller alterations. This chapter explores how they have altered the balance of power between the two most powerful occupational groups, managers and doctors, and some implications for organizational theory.

Weberian organizational sociology asserts that a group's power in an organization depends largely on its positional power, i.e. on the topology of the hierarchies which usually comprise an organizational structure and what place the group occupies within it. Individuals or groups occupying 'high' positions exercise 'position power' over subordinates. The wider the span of control an agent has over inferior levels and the more resources and discretion are delegated to him/her from higher levels in the hierarchy, the greater the superior's power. Despite disagreements as to the relative importance of different sources of power, most theories of power assume that power essentially consists in 'the probability that an actor in a social relationship will be in a position to carry out his own will despite resistance, regardless of the basis on which the probability rests' (Weber 1947; see also Blau 1964; Dahl 1986; Parsons and Shils 1951; Tawney 1938). The exercise of power is thus a zero-sum game whose prizes are the allocation of activities, technologies, economic rewards, formal position, status and other perquisites, and of the means of exercising power in future. Usually the main source of power given by a high 'vertical' position in an hierarchy arises from capacity to allocate the use of physical resources and budgets owned by the organization,

which above all enables the superiors to appoint, promote or dismiss subordinates. In short, it derives from the property relations embodied in formal hierarchical structures. The exercise of power through any of these sources requires that the superiors monitor their subordinates' activity and apply these sources of power to reward compliance with the superiors' wishes and penalize non-compliance. The foregoing tenets imply that because of their positional power managers are the most powerful occupational group in hierarchical organizations.

The early 1990s was a zenith of neo-liberal policies towards the public sector in much of the Anglophone world. In Britain the NHS in 1990 was a 'Beveridge model' system in which the health ministry (Department of Health) and its subordinate local organizations directly managed the providers of NHS hospital services. In 1991 the Thatcher government began to 'reform' this system into a quasi-market one. One arm of the reform was to reconstitute secondary care providers as semi-autonomous 'public firms' which would work under contract to local organizations (Health Authorities) managed by the Department of Health. Commercial providers could also undertake NHS contracts. These measures were intended to promote competition between hospitals for patient referrals, thereby making NHS hospitals more responsive to patients' preferences (Department of Health 1989). The other arm – a belated addition to the reform – was to give primary care doctors the budgets and the responsibility for commissioning a large proportion of secondary care for their patients. Since in England the primary care doctors were (and mostly remain) independent general practitioners (GPs) working under contract to the NHS, this arm of the reform became known in England as 'GP fund holding', although similar reforms were attempted in parts of Sweden and Russia. This arm of the reform was intended to create incentives to minimize referrals to secondary, promote the substitution of primary for secondary care, and so moderate the workload pressures facing NHS hospitals and strengthen cost control.

Since then, the resulting organizational structures in the English NHS have undergone an almost circular evolution. Differentiating itself from the Thatcher government's health policies, the incoming 1997 'new Labour' government announced that 'partnerships' between public bodies would replace the quasi-market between hospitals and health authorities. Primary Care Trusts (PCTs), based on local networks of GPs, would take from individual general practices the 'fund holding' function of commissioning of secondary care. Insofar as they had a coherent programme theory, these changes in organizational structures were described as 'third way' policies (cp. Giddens 1998).

Like neo-liberalism, the 'third way' had followers in many countries besides the UK. By 2004, however, the English government appeared to be losing confidence in third way health policies and began restoring what are in essence (though not in name) the NHS organizational structures of the Thatcher period.

If formal organizational structures alone determined the balance of power between doctors and managers, one would predict that the circular evolution of NHS organizational structures would temporarily perturb the balance but in the end produce little net change in it.

Although some researchers argue that in England some elements of the medical profession gained and others lost power through such changes (e.g. McNulty and Ferlie 2002), others (e.g. Harrison 2002) argue that the net general tendency was to increase NHS non-medical management power over the medical profession and its clinical practice. If so, the explanation for any shifts in the balance of power lies not in the topography of formal organizational structures and who occupies what places in them, but in the processes by which power is exercised within and through those structures. To hypothesize what changes in the non-positional factors might alter the relative power of two occupational groups (managers, doctors) involves summarizing an extensive literature. Leaving aside physical coercion (relevant to power relationships in mental hospitals, prisons and schools but not those between managers and doctors), the analysis of Sheaff et al. (2004a) suggests that the factors most relevant to the present topic appear to be changes in

1. *Environmental factors*: law and regulation; and the medical labour market
2. *A structural factor common to all health care organizations*: the technological centrality of medicine to health care
3. *Specific organizational processes*: the negotiated order between managers and doctors, and medical resistance to management; professional 'discipline'; and ideological control.

To assess the balance of power between doctors and managers empirically, one must therefore examine what changes (if any) have occurred in the above media by which power is exercised in NHS primary care. That is, one must assess what changes have been wrought, in NHS primary care, by changes since 1990 in the negotiated order between managers and doctors; professional 'discipline' and ideological control;

the medical Labour market; the 'technologies' of primary health care; and English law.

The foregoing outlines how occupational managers exercise power within a single organization. However, most health systems are not so much a single organization as a single governance structure within which are nested subordinate governance structures which include hierarchies, networks and quasi-markets through which the health ministry exercises governance, to varying degrees, over the actual providers of health services. The subordinate governance structures include contracts, often but not always special forms of contract peculiar to public sector quasi-markets, and 'arm's-length' governance through what might be called 'boundary-spanning hierarchies'. In England, for example, PCTs are managerially accountable to health authorities (HAs) through essentially the same hierarchical relations as obtained within a single organizational hierarchy, although the two organizations are structurally and legally separate. How far would the foregoing account of position power have to be supplemented or modified to apply to a health system comprised of diverse governance structures, such as English NHS primary care which is a particularly diverse system of small organizations (general practices) and larger ones (PCTs)?

Many of the factors mentioned above (and explained more fully below) operate as much at national level in a health system across all its constituent organizations as within each organization. Indeed, national-level events constrain the latter. For example, the market power conferred by scarcity of labour may be greater at whole-system level because whilst a single organization may recruit more than its proportionate share of scarce labour, such imbalances cancel out system-wide. Medical technological changes, or at least the knowledge they involve, are increasingly disseminated world-wide, let alone nationally. Conceivably an occupational group might be technologically central to a few providers (e.g. acupuncturists, in providers of traditional Chinese medicine), but these providers are atypical health system-wide. Governmentality through professional discipline is adapted to operate across as well as within formal organizational structures, and so are ideological legitimations of power. Thus the foregoing definitions of power and the accounts of the structures and processes through which power is exercised to all translate 'upwards' in generality from organizational to health system level. They apply, however, only in health systems like the NHS which contain a set of governance structures through which someone (government) attempts to exercise governance. (They would not apply in, say, a market.)

This chapter therefore enquires

1. In what ways has the balance of power between English NHS managers and doctors shifted since 1991?
2. How far can these changes be attributed to changed organizational structures and to what extent must other explanations be invoked?
3. What are the implications for theories of managerial and professional power in organizations?

In doing so the chapter focuses mainly but not exclusively on general practice, drawing upon published research, especially for the 1990–97 period, upon primary data from six post-1997 studies in which the author participated in from 1997, and upon the main policy and guidance documents for the whole period.

Negotiated order and resistance

Weber's definition of power mentions the possibility of resistance. If neither agent can dispense completely with the other's role in an organization or in society, the balance of power in organizations must be continuously re-negotiated, creating a 'negotiated order' (Strauss et al. 1963). In the NHS this negotiation occurs through two occupational sub-groups: doctors sufficiently senior to manage other doctors and negotiate with non-medical managers; and the latter group of managers. Indeed, some doctors (also) occupy managerial positions. The outcome, as in any negotiation, appears to depend partly upon how confident of success each party feels in the light of past attempts to apply sanctions; how far they regard it as legitimate to do so; how great they feel the threats to, or the opportunity to advance, their interests to be; and how they anticipate any powerful third party might respond.

Much of the English medical profession opposed the introduction of the NHS internal market and fund holding in 1991. Indeed the British Medical Association (BMA) ran a public campaign of advertisements, press conferences, lobbying of MPs and releasing research study findings supporting their standpoint shortly before the main parliamentary debates. Nevertheless, the reforms were implemented, including a revision of the GP contract to include the first measures of clinical activity and indicative prescribing budgets. The introduction of universal medical audit proceeded under the tacit threat that if the medical profession did not cooperate voluntarily, the government would find regulatory or legislative ways to compel them (NHS chief

executive; personal communication). At national level, where it has long existed, the stratum of doctors mediating between other doctors and NHS management was thereafter on the defensive. Subsequently the English medical profession lacked confidence to take on the state (Armstrong 2002), conceding the stronger, more collective forms of disciplinary control described below.

On the management side, New Labour displayed less confidence than its predecessor. As the political price for participating in PCG/Ts, GPs were given a majority on PCG boards and PCT professional executives and guaranteed representation on PCT boards. The government preferred to 'buy out' GP objections to the closer monitoring of GP clinical work introduced under the 2004 GP contract and the *Quality and Outcomes Framework* (QOF) appended to it. Local medical committees (of the BMA) were generally passive or accommodating to PCG/T formation, clinical governance and successive forms of GP contract; at local level, sustained opposition has been rare. There is some evidence that a stratum of about 10–20% of GPs in most localities have consistently been early adopters of the new disciplines and organizational innovations (GP fund holding, PMS contracts, PCG committee membership). Successive widely publicized medical scandals (e.g. the Shipman, Ledward and Bristol cases) created a perception among GPs (Sheaff et al. 2004b) that if the profession did not adopt more rigorous and transparent forms of quality and safety control, national-level medical organizations, in particular the GMC, would be reformed, with the tacit threat of a stronger non-medical voice in them (Klein 1998). Soft coercion (Courpasson 2000) was also applied to the hospital half of the English medical profession. At local level there has emerged a stratum of doctors who mediate between the profession and NHS management (Sheaff et al. 2002) and who have acquired an interest in reforms which enhance their status, influence over other doctors and voice in NHS management.

Legitimation: ideology and 'discipline'

In both negotiating and managing an organizational 'order', power can also be exercised by an 'institutionalization of authority' legitimating the interests of (in the present case) one particular occupational group and defining the behaviour which they desire as 'binding obligations' (Parsons 1951). Lukes (1974) and Habermas (1976) argue that persuading others to do by means of rational argument is the exercise of authority or influence rather than of power. Conversely, persuading others to do what they would not do if they were fully informed prevents them

from pursuing their own interests, with much the same effect as if sanctions were successfully applied, and is therefore an exercise of power. Many studies (e.g. Fairclough 2005) describe discursive, ideological and rhetorical devices used for these purposes, which include control of policy agendas (Bachrach and Baratz 1970) and insistence on discourse or ideology which does not even allow the formulation of certain topics (Lukes 1974) whilst insisting on others being 'problematized' in a way crafted to legitimate certain preferred 'solutions'. Insofar as an occupational group's working practices can be made transparent to other group members or outsiders or both, that knowledge also functions as 'power-knowledge', for it enables those who scrutinize the occupational group members' activities to apply whatever sanctions (moral, economic or physical) are at their disposal to promote practical compliance with that body of knowledge (Foucault 2004). It functions as a 'discipline' (Flynn 2002).

During the 1990s both managers and doctors have developed new 'disciplines'. Most influential were, respectively, the new public management (Ferlie et al. 2002; Flynn 1992) and evidence-based medicine (EBM) (Harrison 2002).

During the 1990s, and especially after 1997, NHS primary care management experienced a disciplinary shift towards the 'new public management' practices that NHS hospitals began using a decade earlier. PCTs were new organizations intended, unlike their predecessors, to manage rather than just reimburse GP activity. From 1999 PCTs were expected to implement national standards for services. Access targets were now applied to general practices, although 'advanced access' methods of appointment management were usually implemented through a national network of primary care 'collaboratives' rather than by PCTs alone. Above all, PCTs became responsible for ensuring that National Service Frameworks (NSFs) were implemented. To varying degrees NSF standards derived from EBM and the national bodies (above all, NICE) through which the NHS implemented it.

Apart from exceptional events such as gross malpractice or criminality, the topic of how doctors exercised their clinical autonomy was closed to NHS managers until the late 1980s. Since then, new management information and costing systems have gradually increased the transparency of medical practice. This trend began with incentives under GP funding for practices to install management information system (though to the practice's choice and specification). GPs came to record increasing amounts of data for NHS managers' use (Harrison and Dowsell 2002), a trend which QOF dramatically extended. The current

NHS informatics programme aims at comprehensive networking of patient and some administrative data by 2009. Regular independent surveys of patients and public views of NHS services began to be published, besides (according to anecdotal evidence) others which the Department of Health does not publish. Arrangements were introduced in 2002 for identifying and 'helping' doctors whose 'performance gives cause for concern' (Department of Health 2000). These systems were managerially instituted but still professionally operated and predominantly educational.

Within medicine EBM was the central medium for broader and closer disciplinary control over GPs' clinical work, a control that shifted from exception management towards governmentality over mainstream clinical practice and from an individual to a collective form of professional self-regulation and professional autonomy. The universal, but relatively weak, predominantly educational form of medical audit introduced in 1991 was from 1998 supplanted by two forms of disciplinary control based on EBM. Medical audit and local professional networks were reconstituted as clinical governance networks, of which GP membership was compulsory. Nevertheless clinical governance was often initiated by a core of 'early adopter' doctors, gradually involving other GPs through peer influence later. Other clinical professions, especially nursing, either had their own, more fragmentary clinical governance networks or participated *ad hoc* as semi-detached members of the medical networks on an issue-by-issue basis. QOF (see above) greatly extended the range of clinical quality standards to be implemented. Despite the contractual sanctions (financial rewards and penalties) attached to them, its standards were also largely evidence-based. These disciplinary changes also tended to re-medicalize general practice. EBM was more readily applied to, and legitimated, the biologically oriented aspects of clinical practice. Nevertheless EBM increasingly became a disciplinary tool common to both managers and doctors.

With decreasing lags the ideological climate in NHS management tended to follow that of the current government. Despite the change of party in government, the deepest policy difference between them (whether to contain or greatly expand the level of NHS spending) was not strongly reflected in the managerial ideologies of the period. Indeed the ideological continuities are more striking than the discontinuities, in particular the rhetoric of 'reform' ('change', 'modernization', 'new' policies) even though many of these changes (e.g. introduction of commercial and charitable providers) revert to pre-NHS policy. New Labour initially emphasized its ideology of 'no ideology' (the 'third way')

and the slogan ‘what matters is what works’, which abstracts from the contentious question of precisely what the reformed working practices are meant to achieve, as though that point was already well defined and generally agreed. Its positive focus, though, is on day-to-day managerial and clinical work and innovations in both, with the implication of normalizing ‘what works’. New Labour also accepts, indeed often states, the idea that health professionals, especially doctors, represent patients’ interests. One rationale for each successive reform has been that it will allow clinicians to practice more freely and to influence the details of service management.

As for medical ideologies, the gradual GP uptake of salaried employment appears to suggest that GPs’ hitherto powerful, near-universal aversion to it is weakening. English GPs have remained sensitive that new working methods be adopted voluntarily, not imposed by non-doctors. The emerging stratum of GP medical managers (see above), however, ‘turns’ this belief so as to legitimate their own new roles in terms of buffering general practices against the demands of (lay) NHS management. Closer regulation by fellow GPs remains a lesser evil for GPs than managerial control. Although a steady trickle of individual jeremiads have appeared in the professional press and researchers report certain GPs’ passive resistance and scepticism towards the ‘reforms’, there have been few ideological challenges to the new disciplinary controls in medicine. The most coherent counter-argument contrasts the ‘art’ and ‘holism’ of general medical practice with EBM (Armstrong 2002). Yet it is also reported (Sheaff et al. 2003) that the argument that (say) NSFs are ‘national policy’ helps legitimate them to GPs, who reconcile this view with their preference for professional autonomy by saying that the policy coincides with local health needs. The tacit ideological outcome is that it is legitimate for national policy, represented by NHS management, to influence general practice *provided* this influence is mediated and buffered by local GP leaderships.

The labour market

An occupational group’s market strength depends above all on how vulnerable managers are to that group disrupting production of the organization’s main output. The greater the demand for its outputs and the more alternative providers exist, the more an organization stands to lose financially if an occupational group disrupts production, so the greater that group’s power. The smaller the excess supply of labour in that occupation is, the harder it is for managers to

replace non-compliant members and the weaker a sanction the threat of dismissal is. The limiting case is an organized monopoly in labour supply which managers cannot get individual members to defect from. The non-substitutability of members of an occupational group maximizes its power.

Demand for GPs' services increased, due to not only the expanding and ageing English population but also (from 1997) tightening targets for hospital waiting times, which increased demand for primary to replace secondary care at either end of the hospital episode. There were a few experiments with placing GPs in accident and emergency (A&E) departments, not widely copied. After 1997, GPs' increasing role in PCT management placed another demand on their time. Under the 1990 GP contract, GP cooperatives instead of commercial deputizing firms increasingly provided out-of-hours services, until the 2004 contract allowed GPs to relinquish responsibility for OOH services altogether, which many did. PCTs took over that responsibility.

Throughout the study period there was an intensifying shortage of GPs, especially in poor urban areas. No national data are collected on 'vacant' (doctor-less) general practice lists but the author has found the problem repeatedly discussed by NHS managers, reported in the professional and managerial press and in research (e.g. Gosden et al. 2000; Williams et al. 2001) evaluating possible solutions. The new medical schools opened too late to affect the shortage during the study period.

Technological centrality

There is also a technical sense in which a whole occupational group, rather than just its individual members, may or may not be substitutable. The Aston school argued that besides its place in the 'vertical' and 'horizontal' topography of an organizational structure, an occupational group's power depends on the group's relationship to the technology (physical equipment and processes) used for conducting the organization's core activity (Abell 1975). (Here the concept of 'technology' is taken widely to include, for instance, 'technologies of repression'; (Foucault 1977).) A group operating the technology possesses the potential sanction of disrupting the organization's capacity to pursue its objectives, that is, the power to determine whether those who formally control an organization actually can use its resources to pursue their particular objectives. This type of power depends on how far substitutes exist for

1. The occupational group which operates a given technology. The fewer are the alternative occupational groups that can do so, the more powerful is the occupational group who can.
2. The technology itself. The fewer the technologies which can replace it, the more powerful the occupational groups who can operate that technology.

Since this power derives from the productive process, it is not necessarily (indeed, typically not) reflected in the hierarchical position of the relevant occupational group. When it is collectively exercised, that typically happens through informal organization (trades union, unofficial action) or semi-detached (above all, professional) organizations. So, *pace* some claims (Fairclough 2005), not all social practices, and not even all technologies, are equally important in terms of power.

NHS management therefore explored whether other occupational groups were competent to substitute, at least partly, for GPs as points of first clinical contact for non-emergency patients. The main jurisdictional changes in occupational groups were introduction of nurse practitioners (Chambers 1998; Venning et al. 2000); nurse principals; Evercare nurses and their equivalents (EPIC nurses, community matrons etc.; Boaden et al. 2005); physician assistants; retail pharmacists (Hassell et al. 2001); and nurse triagers (Hanlon et al. 2005). The extent to which these could replace GPs varied but generally these new occupational groups' professionals took over the less complex elements of GP work and worked under medical (usually GP) clinical supervision and mentorship. The net effect was to make GPs' work more medical, reducing GP centrality for the less complex aspects of primary care 'technology' and maintaining it for the more complex.

These skill-mix changes were also partly a concomitant of substitute primary care technologies, developing for the same reasons. The main innovations were walk-in centres; NHS Direct (Hanlon et al. 2005); case management (e.g. Evercare, EPIC and similar projects, now promulgated nationally as the 'Community Matron' programme; and, more rarely, dedicated primary care clinics within or near hospital A&E departments. NHS Plus, established in 2000, provides OH services to non-NHS employers. Still relatively small, it nevertheless provides a service which by default general practice mostly provided. To provide for vacant lists and, after 2004, to provide out-of-hours services, PCTs gradually began directly employing salaried doctors and to a limited extent nurse practitioners. To a limited extent these new 'technologies' offered a substitute for independent GPs as providers of primary care, eroding the independent GPs' centrality.

Law and regulation

Whilst the everyday rule of law depends heavily on ideological legitimation, legal power is distinct in resting ultimately upon the state's greater capacity for physical coercion than any other organization or social group. What effect law, regulation, legally binding contracts and judicial interpretation have upon the balance of power between doctors and managers depends upon the normative content of the law and how it is enforced. The former can simply be 'read off' from the relevant documents, in the present case those which establish, define and enforce any limits to the roles, rights or substitutability of occupational groups. The sanctions can be discovered partly in the same way, but also by examining how law and regulation are in practice enforced, and to whose benefit.

In NHS primary care the most important legal and regulatory development was to make GP contracts more 'complete' and more contestable. The 1967 GP contract was little more than a reimbursement mechanism but from 1990 each revision introduced closer specifications of the clinical work expected from GPs. The 1990 contract introduced vaccination and immunization targets and delegated 'indicative' budgets for pharmaceutical spending. GP fund holding added responsibility for budgets for much of secondary and some primary care, though not for primary medical care itself except prescribing. From 1998 GPs had the option of taking a locally negotiated PMS contract rather than the standard national ('GMS') contract. PMS contracts set practice-specific targets, though usually broadly defined and weakly monitored (Sheaff and Lloyd-Kendall 2000). The QOF and 2004 GMS contract made general practice incomes depend on the degree of compliance with around 130 evidence-based indicators of clinical processes and, in a few cases, outcomes. PMS and the 2004 GMS contracts both defined the contract agent as the general practice (organization) instead of the general practitioner (named doctor) as before. Such a contract therefore survives changes in medical personnel including, in theory, the ousting of individual GPs for disciplinary or other reasons.

GP contracts have also been made more contestable through the introduction of organizational substitutes for the professional partnership model of general practice as small businesses. GP co-operatives providing out-of-hours services were first permitted under the 1990 GMS contract, gradually becoming more widespread (Hallam 1997) and, after 1997, wider in the range of services they provided although the 2004 GP contract precipitously reduced their number. The 1997

NHS Act also relaxed the conditions under which PCTs and general practices were permitted to employ salaried GPs. The Innovations in Primary Care Contracting policy creates a framework by which PCTs can contract other organizations to substitute for general practices in providing primary medical care. This policy is still at an early stage of implementation, but one attempt has already (2006) been made to replace a general practice (N. Derbyshire) with provision by a US for-profit HMO and then, when that failed due to local opposition, a British private provider. At the time of writing ten pilot site PCTs have been seeking and evaluating bids from providers other than existing general practices to provide primary health care.

What shifts in power between medicine and management in English primary care?

On the evidence of payment alone GPs would appear more powerful in 2006 than in 1991. They are highly paid by European standards and the 2004 contract considerably increased their incomes. The actual data are secret but GP remarks in the professional and national press point towards GPs' income typically being about 20–30% higher than before, and this for a workload reduced, in most cases, by ceasing out-of-hours work. GPs have a privileged role in PCT management compared with other clinical professions and, still, higher occupational status. With NHS managers, GPs are partners in a dominant coalition over NHS primary care.

However, the price for these gains has been that through the medium of professional discipline, the locus of control has clearly shifted (albeit from a low starting point) towards NHS management, who now exercise greater regulation and surveillance over GPs' work and are starting to normalize it on terms decided predominantly by management. Disciplinary changes in both medicine and management have led unidirectionally towards the greater regulation and surveillance of GPs' clinical practice. Ideological rationales for health reform and closer disciplinary control have largely won the day among GPs, in the absence of coherent alternatives.

As for labour market power, demand for services which GPs supply continues to increase. Yet this very trend has provoked skill-mix changes, the introduction of new forms of service (e.g. community matrons) and admitting new providers to NHS primary care. These changes create partial substitutes for general medical practice and attenuate its scarcity. A greater division of labour is slowly limiting GPs'

technological centrality to a narrower range of more specialized work. Organizational substitutes for the self-employed partnership model of general practice have also begun to appear, eroding the bedrock of GP's financial and organizational autonomy. At critical junctures in NHS reform (1992, 2000–02) the English medical profession was on the defensive and made concessions to government, despite New Labour also buying GP support for their reforms with income and managerial influence. A layer of medical managers has emerged with an interest in disciplinary, and by proxy managerial, control over other doctors. Together these trends suggest a net strengthening of NHS managerial control and a reduction in GPs' professional autonomy, both individual and collective. Gradually power has been draining from medicine to management in NHS primary care. This effect, and the organizational processes which have brought it about, partly belie the similarities between the present-day NHS organizational structures and those of the 1990s.

Similar organizational structures, different power-relations

Fifteen years of successive organizational 'reform' have ended up leaving English NHS organizational structures essentially as they were in 1991, except for the addition of a minority of salaried GPs. Yet although the organizational structures have essentially returned to those adopted by the Thatcher government, the balance of power between doctors and managers has not.

This history provides further evidence that an occupational group's positional power is not defined purely by occupancy of a privileged or a 'high' position in an hierarchical organizational structure. Rather, the ability of an occupant of such a position 'to carry out his own will despite resistance' is exercised through the whole complex of organizational processes and technical conditions outlined above. Organizational, policy or technical changes generally involve some combination of re-negotiation of practical, everyday working activities; re-interpretation of laws and regulations; decision-making, to that extent legitimating managers' positional role as decision-makers; new activities to which technical and professional 'disciplines' are applied; redefining divisions of labour within and between occupational groups; and opportunities to introduce new production techniques ('technologies'). Such events present each occupational group with the question of whether it would be legitimate and feasible for them to resist or to exploit the changes under way. Reallocations of budgets, staff and physical resources are

made through these processes in combination, making these processes the media through which positional power is reproduced, i.e. simultaneously both exercised and modified. Repeated changes to formal organizational structures are no exception to this pattern, so that at the end of them all the balance of power between managers and doctors is likely to have shifted even though in terms of formal organizational structures and roles the parties are almost back where they started. To that extent, Courpasson (1998) is right to say that 'change is a political tool'.

Exactly the same considerations apply, however, to the effects of such changes on the power of the non-managerial occupations. Furthermore, organizational change is sometimes not so much an occupational group's 'tool' as an accident which befalls them. Depending on the circumstances, unplanned changes in the development of natural sciences can alter the balance of power between (in this case) managers and doctors. So can unforeseen events which expose any half-truths, fallacies or inconsistencies in occupational and political ideologies. Since power is essentially contested, the outcomes of the processes through which it is exercised are liable to be uncertain. The interaction of these planned and unplanned changes is what defines and redefines the content and scope of 'positional' power in most organizations.

Such findings remind organizational researchers of the futility of attempting to understand organizational structures and organizational processes in isolation from each other when analysing power in organizations. It is through the organizational processes noted above that the property rights attached to a specific position in an organizational structure are exercised and in doing so the positional power which they give is reproduced, strengthened or weakened. Conversely, each occupational group's role in the organizational structure determines what resources the group brings to its participation in these organizational processes and what interests each group pursues in doing so. An organizational structure thus constrains the range of organizational processes that occur within it. For example, in England, attempts at monitoring policy implementation, disciplinary control and non-medical managerial control in general practice have long been constrained by the structural independence of general practices. This raises the research question of how far, and in what ways, the new organizational structures and property-relations recently created by the salaried employment of GPs by NHS PCTs and by the emergence of further organizational varieties of primary health care provider will accommodate or even produce changed organizational processes (e.g. for decision-making, resource

allocation, management of clinical quality) within English primary care. This question is currently being empirically researched.

A policy lesson from English NHS primary care reform is that even without changes to health system organizational structures, changes in managerial – that is, disciplinary, ideological, negotiative and re-allocative – processes can produce at least modest shifts in the balance of power between independent-contractor doctors and managers. Yet in the minority of cases where the structural position of GPs has changed to that of salaried employee of the NHS, the balance of power, in the sense of degree of managerial control, appears little different to that where GPs remain independent contractors. One possible explanation is that the salaried GPs tend to hold hard-to-fill posts, making PCTs hesitate to exercise the power which this hierarchical relationship might in theory provide. However, there is also evidence that at least one of the newly contracted private providers of primary care, which also employs salaried GPs in similar settings, has no such reluctance. In England at least, a more thoroughgoing privatization of NHS primary care might constrain medical power more narrowly than incorporation into a public bureaucracy does.

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Author Index

- Abell, P., 10
Abelson, J., 123–5, 135
Ackroyd, S., 210, 211, 219
Aldrich, H. E., 68
Alexander, J. A., 64
Alford, R., 212, 220
Allen, D., 41
Allsop, J., 215
Alvesson, M., 77, 80
Anderson, N., 69
Armstrong, D., 6, 9
Armstrong, G., 195
Atun, R., 53
Axelrod, R., 141
Axelsson, R., 76, 78
- Bachrach, P., 7
Badham, R., 167, 168, 169, 171, 178
Balas, E. A., 157
Banaszak-Holl, J., 194, 195
Baratz, M. S., 7
Barley, S. R., 167
Barnes, M., 91, 124
Bate, P., 112
Baum, J. A. C., 196
Baxter, N. N., 65
Becker, B. W., 205
Beierle, T. C., 124
Berkley, J. D., 212
Bertalanffy, L. V., 155
Best, A., 154
Bitner, M.-J., 195
Bjoke, C., 216
Blackler, F., 92
Blau, P. C., 68
Blau, P. M., 1
Bloch, R. M., 180
Boaden, R., 11
Bogason, P., 143
Bojke, C., 64
Bonifazi, W. L., 205
Bouckaert, G., 209, 212
- Bovaird, T., 142, 144
Bowen, S., 88
Braithwaite, J., 33, 35, 36, 38, 40, 41
Breslin, F. C., 108
Briner, R., 76
Brocklehurst, M., 33
Brown, T., 22
Brugha, R., 22
Buchanan, D., 168, 169, 171, 178, 189
Burgelman, R. A., 38
Burns, D., 47
Burrell, G., 77
Buss, D., 196
- Calhoun, J. G., 194, 198, 201
Callon, M., 180
Cameron, M., 140
Campbell, C., 161
Capra, F., 155
Carillo, H., 200
Casebeer, A., 123
Castle, N. G., 195
Causer, G., 218
Cayford, J., 124
Cayton, H., 135
Cereste, M., 37
Chaiken, M. A., 194
Chambers, N., 11
Chambers, R., 140
Chantler, C., 42
Child, J., 64, 68
Christianson, J. B., 68
Church, J., 124
Clark, J., 20
Clarke, L., 205
Clegg, S. R., 35
Clemens, E. S., 168
Coburn, D., 102
Cohen, A. R., 101
Congdon, P., 22
Conlon, D. E., 194, 195
Cook, J. M., 168

- Coote, A., 95
 Côté, M., 155
 Coulter, A., 52
 Courpasson, D., 6, 15
 Craig, D., 95
 Cranfield, S., 81, 140
 Creed, W. E. D., 169
 Crowley, W. F., 157
- Dacin, M. T., 168
 Daft, R., 168
 Dahl, R. A., 1
 Damanpour, F., 65, 67, 68
 Davies, H., 76
 Dawson, P., 181
 Dawson, S., 183
 Day, P., 52, 53
 De Vries, M., 51
 Deatrick, J. A., 103
 Deetz, S., 76, 77
 DeMoro, D., 102
 Denis, J. L., 181
 Dent, M., 82
 Di Maggio, P., 34, 41, 42
 Dickinson, H. D., 124
 Disken, S., 42
 Dixon, J., 124
 Donaldson, L., 35, 36
 Donovan, C., 76
 Dopson, S., 76, 180, 182, 183,
 184, 186
 Dowling, B., 59, 150
 Dowsell, G., 214
 Dowswell, G., 7
 Drazin, R., 69
 Duckett, S. J., 36, 39
 DuGay, P., 215, 220
 Durkheim, E., 68
- Eaton, S. E., 100, 101
 Eisenhardt, K. M., 114
 Ellis, P., 157
 Emirbayer, M., 168
 Erdos, G., 100
 Evanisko, M. J., 65, 180
 Exworthy, M., 46, 47, 49, 50, 51, 53,
 55, 209, 210, 211, 212, 213, 215,
 216, 217, 218, 219, 220
- Fagin, C. M., 102
 Fairclough, N., 7, 11
 Fairhurst, K., 180
 Feldman, R., 64
 Ferguson, B., 20, 64
 Ferlie, E., xi, xxiii, 3, 7, 53, 59, 71,
 180, 181, 182, 187, 190
 Fetter, R. B., 36
 Fink, S. L., 101
 Fitzgerald, L., 41, 180, 181, 182, 184,
 185, 186, 187, 189, 191
 Fligstein, N., 168, 169
 Florin, D., 124
 Floyd, S. W., 169, 176
 Flynn, L., 103
 Flynn, R., 7
 Forest, P.-G., 123
 Forrester, J. W., 155
 Forsyth, G., 59
 Foucault, M., xviii, 7, 10, 144, 213,
 218
 Francois, C., 155
 Freeman, G., ix
 Freeman, J., 64
 Freeman, J. H., 68
 Freidson, E., 210, 211, 220
 Frisby, W., 162
 Fuerburg, M., 100, 101
 Fuller, S., 83
 Fulop, N., 19, 21, 22, 23, 25, 27, 29,
 31, 37, 40, 64
- Gabbay, J., 112, 183
 Gaebler, T., 49, 50, 52
 Garside, P., 37
 Gask, L., 22
 Gass, T., 101
 Gell-Mann, M., 155
 Georgopoulos, B., 59
 Germain, R., 65
 Geyman, J. P., 107
 Giddens, A., 2, 34
 Glennerster, H., 21
 Goddard, M., 54, 64
 Golden-Biddle, K., 167, 169, 170, 171,
 173, 175, 177
 Gooding, R., 64, 67, 68
 Goodwin, N., 22
 Gordon, S., 102, 106

- Gosden, T., 10
 Grabowski, D. C., 102, 103
 Grafton-Small, R., 82
 Graham, K. A., 124
 Graham, P., 140
 Gray, A., 51
 Gray, J., 51, 97
 Green, J., 75
 Green, S.E., 167, 169, 170
 Greener, I., 46, 47, 48, 49, 50, 51, 53,
 54, 55
 Greenhalgh, T., 91, 155, 157, 158,
 159, 169
 Greenwood, R., 167, 170
 Greer, S., 48, 51, 53
 Greer, S. L.95
 Greiner, A., 102
 Greiner, L., 68
 Grey, C., 77, 78
 Griffiths, R., 92-93
 Grimshaw, J., 157
 Grint, K., 213
 Grob, G., 100
 Guinn, R. M., 41
- Habermas, J., 6
 Hales, C., 51
 Halford, S., 212, 220
 Hallam, L., 12
 Halm, E., 20
 Ham, C., 59, 189
 Hanlon, G., 11
 Hannan, M. T., 64, 68
 Hardy, C., 35
 Harrington, C., 194, 195, 200
 Harrington, C. S., 197, 200, 210
 Harris, M., 22, 29
 Harrison, S., 3, 7, 51, 92, 209, 214, 220
 Harvery, J., 100
 Hassell, K., 11
 Healy, J., 19
 Hearld, L., 194
 Heitlinger, A., 102
 Hensmans, M., 168
 Hetherington, R. W., 64
 Hewa, S., 64
 Hewison, A., 76
 Hickson, D. J., 68
 Hill, C. W. L., 36
- Himmelstein, D. U., 107
 Hindle, D., 33, 36
 Hoggett, P., 209, 210, 213
 Holland, J. H., 155
 Howard, E., 102
 Huby, G., 180
 Hunter, D., 188
 Hunter, D. J., 87, 89, 91, 93, 95, 97
 Huxham, C., 140, 151
- Iedema, R., 33
 Iles, V., xxv, 81, 82, 83
 Ingram, P., 196
 Issel, L. M., 64
- Jack, G., 77
 Jarman, H., 48, 51, 53, 95
 Jennings, D., 70
 Jochelson, K., 91
- Kaldenberg, D. O., 205
 Kamens, D. H., 34
 Kane, R. A., 194, 195
 Kane, R. L., 194
 Kauffman, S., 38
 Kauffman, S. A., 155
 Kerner, J., 157
 Khan, K. S.62
 Khan, R. L., 68
 Kiefer, L.,158
 Kilborn, A., 104
 Kilbreth, E. H., 124, 125
 Kimberly, J. R., 65, 69, 180
 Kitchener, M., 22, 194, 209, 210, 211,
 212, 213, 215, 217, 219
 Klein, R., 6, 47, 48, 49, 52, 53, 213,
 214
 Kohler, P. O., 194
 Korman, N., 21
 Kotler, P., 195
 Kovner, A. R., 76
 Krlewski, J., 64
 Krlewski, J. E., 68
- Lamarche, P., 161, 162
 Lamm, R. D., 106
 Lane, V. R., 195
 Lathrop, J. P., 33, 41
 Law, J., 150

- Lawrence, P. R., 35
 Le May, A., 112
 Learmonth, M., 75, 77, 79, 81, 83
 Leatherman, S., 194
 Leatt, P., 41
 Lee, C. A., 34
 Lee, K., 65
 Lee, S. Y. D., 64
 Lewis, R., 52
 Lindblom, C., 143
 Linstead, S., 82
 Lister, J., 142
 Litva, A., 124
 Ljungberg, A., 104
 Ljunggren, B., 64
 Llewellyn, S., 80
 Lloyd-Kendall, A., 12
 Locock, L., 180, 184, 188, 190
 Logan, R., 59
 Lomas, J., 157, 192
 Lorsch, J. W., 35
 Loundon, I., 214
 Lowe, T., 195
 Lukes, S., xxviii, 6, 7
 Lundstrom, T., 100
- Macalpine, M., 139, 140, 141, 143,
 145, 147, 148, 149, 151
 Macinko, J., 161
 MacKean, G., 123
 Maddock, S., 148
 Maguire, S., 168, 169, 176, 177
 Maloff, B., 123, 124
 Mankoff, S. P., 157
 Mannion, R., 54, 59
 Mansfield, R., 64
 Marceau, L.D., 157
 Marmor, T., 46
 Marmor, T. R., 49
 Marmot, M., 90
 Marsden, P. V., 64
 Marsh, S., 139, 140, 141, 143, 145,
 147, 149, 151
 Marshall, M., 59
 Masten, S., 70
 May, A., 112
 McKee, L., 21
 McKee, M., 19, 20
 McKelvey, B., 155
- McKinlay, J. B., 157
 McNally, R., 59
 McNulty, T.3, 71, 181, 190
 Meyer, J. M., 34
 Meyer, J. W., 196
 Meyer, M., 68
 Meyer, P. G., 64
 Meyerson, D. E., 168, 169, 176, 177,
 178
 Miller, P., 219
 Mintzberg, H., 47, 211
 Mische, A., 168
 Mitchell, P. H., 59
 Moch, M., 64
 Moore, M., 49, 50, 53
 Mor, M., 64, 70
 Mor, V., 197
 Morgan, G., 77
 Morgenstern, O., 155
 Morone, J. A., 124, 125
 Morse, E., 64
 Morse, J. M., 75
- Needleman, J., 107
 Newell, S., 190
 Newman, J., 53
 Nilakanta, S., 64
 Nohria, N., 211
 Norman, Cameron D., xviii, 154
- O'Sullivan, M., xviii, 99, 101, 103,
 105, 107, 109
 Osborne, D., 49, 50, 52
 Ozcan, Y. A., 76
- Packwood, T., 42
 Parker, M., 82
 Parkinson, C. N., 68
 Parkinson, J., 22
 Parsons, T., 1, 6
 Peckham, S., 50, 51, 53, 213, 216
 Pelikan, J. A., 41
 Perrenoud, B., 181
 Peters, T. J., 81, 82, 83
 Pettigrew, A., 19, 21
 Pettigrew, A. M., 113, 181
 Pfeffer, J., 68, 73, 76, 77, 83
 Phillips, S. D., 124
 Plowden, W., 49

- Plsek, P., 91
 Plsek, P. E., 155
 Pollitt, C., 46, 50, 52, 55, 88, 209, 212, 215, 220
 Pollock, A., 94, 95, 142
 Poole, M. S., 113
 Pope, C., 112, 113, 115, 117, 119, 121
 Potter, J., 77
 Powell, M., 50
 Powell, W. W., 34, 35, 41, 42
 Power, M., 218
 Pratt, J., 140
 Premfors, R., 49
 Preuss, G., 102
 Priem, R., 69, 70
 Propper, C., 51
 Pugh, D. S., 68

 Ragin, C., 221
 Rantz, M. J., 101, 103
 Rao, H., 196
 Reay, T., 167, 169, 171, 173, 175, 177
 Reed, M., 212
 Relman, A. S., 33
 Rhodes, R., 51
 Richardson, G. P., 155
 Rivers, P. A., 41
 Robert, G., 122
 Roberts, I., 82
 Robertson, M., xxxiii
 Rogers, E., 65, 169
 Rondinelli, D., 53
 Rousseau, D., 76, 77
 Rowan, B., 34, 196
 Rundall, T., 76, 78, 79
 Ryff, C. D., 157

 Sackett, D., 75
 Saint-Martin, D., 49
 Salaman, G., 81, 82
 Salancik, G. R., 68
 Saltman, R., 46
 Schein, E. H., 101, 106
 Schnelle, J. F., 103
 Schofield, J., 51, 59, 61, 63, 65, 65, 67, 69, 71
 Schon, D., 139
 Scott, T., 55, 79

 Scott, W. R., xxx, 165, 171, 209, 210, 211, 212, 219
 Scully, M. A., 168, 169, 176, 177
 Seaman, S., 70
 Sen, K., 33
 Seo, M-G., 113, 169
 Sheaff, R., xix, xxiv, xxviii, 1, 3, 5, 6, 7, 9, 11, 12, 13, 15, 59, 63, 220, 221
 Shergill, G. S., 36
 Shi, L., 161
 Shils, E. A., 1
 Shortell, S. M. M., 59
 Sikorska-Simmons, E., 100
 Silverman, D., 34
 Singer, B. H., 157
 Sjoden, P., 64
 Slatin, C., 99
 Smedley, B. D., 157
 Smith, H. L., 64
 Smith, J., 54
 Smith, N., 42
 Smith, P., 76, 217
 Spears, N., 65
 Spector, P. E., 198
 Spitzer, A., 181
 Spurgeon, P., 19, 20
 Stacey, R. D., 155
 Starfield, B., 161
 Sterman, J., 155
 Sterman, J. D., 155
 Stevens, S., 48
 Stewart, J., 98
 Stewart, R., 76
 Strangleman, T., 82
 Strauss, A., 5
 Strauss, A. L., 34
 Street, A., 55
 Strogatz, S. H., 155
 Stummer, C., 22
 Sturt, J., 41
 Subramanian, A., 64
 Sung, N. S., 157
 Sutherland, K., 81, 82, 83
 Sutton, R., 76, 77, 86
 Swan, J., 187
 Syme, S. L., 157

- Taft, S. H., 41
 Talbot, C., 54
 Tawney, R. H., 1
 Tenbenschel, T., 76
 Thatchenkery, T., 152
 Thomas, R. K., 195
 Thurston, W. E., 124
 Toffler, A., 68
 Tolbert, P. S., 41, 167
 Tomlinson, F., 142, 144
 Tonn, J., 151
 Townley, B., 213
 Tranfield, D., 76
 Traynor, M., 75
 Trochim, W., 155
 Trochim, W. M., 156
 Tucker, S. L., 64
- Ulrich, C. M., 102
 Upadhyaya, P., 152
 Urbach, D. R., 65
 Urry, J., 150
- Van de Ven, A.69, 113, 180
 Vancil, R., 50
 Vangen, S., 140
 Varvasovzky, Z., 22
 Vaughan, D., 209
 Venning, P., 11
 Vidler, E., 53
 Vigoda, E., 124, 135
 Vladeck, B. C., 101
 von Neumann, J., 155
 Vrangboek, K., 50
- Waehrer, G., 101, 103
 Wagner, J., 64, 67, 68
 Waldrop, M. M., 155
 Walshe, K., 76, 78, 79, 194, 216
 Wan, T. T. H., 65
- Wanless, D., 93
 Waterman, R. H., 81, 82, 83
 Watson, D. E., 161
 Watts, D. J., 155
 Webb, A., 140, 147
 Weber, M., 1, 5, 212
 Webler, T., 124
 Weech-Maldonado, R., 195
 Weick, K., 151
 Weick, K. E., 167, 171
 Weil, T., 37
 West, M., 69
 West, M. A., 69
 Westbrook, M., xx, 33
 Westwood, R., 77
 Wholey, D., 64
 Wholey, D. R., 68
 Wildavsky, A., 87, 89, 91, 96, 97
 Wilkin, D., 64
 Williams, J., 10
 Willmott, H., 80, 82
 Wilson, B., 108
 Wilson, D., 108
 Wilson, T., 155
 Wiseman, V., 124
 Wood, M., 183
 Wooldridge, B., 169, 176
 Woolhandler, S., 107
 Wunderlich, G. S., 194
- Yin, R. K., 114
 York, N., 215, 217
 Young, R. C., 38
- Zhang, X., 102, 103
 Zilber, T. B., 169
 Zinn, J., 64, 70
 Zinn, J. S., 64, 70, 195, 197
 Zucker, L. G., 41
 Zwi, A. B., 88

Subject Index

- access targets, 7
- adaptive systems theory, 154
- Alberta, 123, 124
 - nurse practitioners, 167, 170, 176
- Alvesson, M., 80
- AN-DRGs, 36, 38
- Arnstein, 124–5
- a-social evidence, 80
- Australia (restructuring), 37–43
- autonomous control (work), 210–1
- autonomy, professional, 8
- Axelsson, R., 78

- Bedford hospital, 48
- Beveridge model, 2
- Bogason, P., 143
- Bristol Royal Infirmary, 6, 48
- British Medical Association, 5
- business process reengineering, 190, 213

- Calgary, 125, 126, 133, 134, 135
- Canada, 123, 156, 158, 162
 - see also*, Alberta, Calgary
- cancer, research, 156
- capacity, developing, 189–90
- case management, 11
- Cayton, H., 135
- centralization, 47, 49–50, 51–2
- chains of decision-makers, 151
- change, 15, 167–70, 171–4, 181, 189–90
- Children's Centres, 147
- Clark, T., 81
- clinical audit, 218
- clinical governance, 218
- clinical governance networks, 8
- Commission on Social Care Inspection, 53
- Community Matron programme, 11
- compensation (workers) costs, 105

- concept mapping, 156
- contexts, micro, 185–7
- contexts, receptive, 189–90
- contingency factors, 35, 40
- contingency theory, 69
- control, custodial, 211–12, 220
- cultural control, 220
- culture, organizational, 82, 101
 - of healthcare (US), 100–2
- custodial control (work), 211–12, 220
- cutback management, 19

- decentralization, 46, 49, 50–1
 - and planning, 55
- demand, GP services, 10
- diagnosis related groups (DRGs), 36
- discourse and policy, 143–8, 150
- doctors, mediation role, 6
- Donaldson, L., 35
- duomorphism, 42

- earned autonomy, 54
- economies of scale, 64
- education, multi professional, 191
- effectiveness, public involvement, 123
- efficiency, and structure, 40, 41–2, 43
- efficiency, conceptualising, 36–7
- elective care, 53
- entrepreneurs, political, 167, 169, 171
- equity, and decentralization, 50–1
- evaluation studies, 22, 112, 128–32
 - treatment centres (NHS), 114–20
- evidence, enactment of, 188–9, 191
- evidence, hierarchies of, 187
- evidence-based
 - health care, 75, 180, 187
 - innovation, 187–8
 - management, 76–8, 79, 80–3
 - medicine, 7, 8, 75
 - policy, 90, 181
 - practice, 75, 77
- externalization, 145

- facilitation roles, 191
- fitness landscape, 38–40, 39(fig 3.1), 39(fig 3.2)
- Foundation Trusts, 21, 30, 50, 52–3
- fund holding, 5
- general management, 215
- General Medical Council, 6, 218
- general practice, modes of control, 213–19
- governance, (post)-bureaucratic (GPs), 215–18
- governance, arm's-length, 4
- governance structure, custodial (GPs), 214–15
- governance structures, 4
- GP contract, 5
- GP contract 1967, 12
- GP contract 1990, 10, 12, 215
- GP contract 2004, 6, 10, 12, 217, 218
- GP co-operatives, 12
- GP fund holding, 2, 12
- GP managers, 9, 13
- GPs, 10, 11, 13, 14, 16
- GP work control, modes, 213–15, 214(*tab.16.2*), 215–19
- guru theory, 81
- habituation, 41
- Hard Facts, Dangerous Half-Truths and Total Nonsense: Profiting from Evidence-Based Management*, 76
- Health Action Zones, 91
- health and safety, 103, 108
- Healthcare Commission, 47, 53, 218
- health check, 55
- Health Concern, 21
- health promotion (children), public involvement, 126–36
- Health Services Research Foundation, 181
- health technology appraisal agency, 218
- heteronomous control (work), 212, 220
- hierarchical structures, 2
- hierarchies, boundary-spanning, 4
- hospitals
 - and efficiency, 41–2
 - structural types, 38
 - symbolic role, 19, 30
- ideological continuities (change), 8
- ideologies, medical, 9
- Iles, V., 82
- implementation
 - of change, 28–9
 - processes, 181
- influence, 6
- information system, management, 7
- innovation, diffusion of, 187–8
- innovation process, 180
- innovations (large organizations), 64
- Innovations in Primary Care
 - Contracting policy, 13
- innovation study (methodology), 182–5, 183–4(*tab.14.1*)
- inspection, 51
- institutionalized practices (changing), 168–70
- integration (intermediate care), 149(*box.11.1*)
- interactive model, policy-making, 89, 97
- intermediate care (integration), 149(*box.11.1*)
- internal market (NHS), 5, 216
- interpretive approaches (policy making), 93
- ISIS (US NCI), 154–6
- isomorphism, 41, 42
- Keeping the NHS Local, 21, 22
- key targets (and reconfiguration), 28
- Kidderminster hospital, 20
- King's Fund, 95
- knowledge, spreading, 191–2
- knowledge and power, 76
- knowledge-driven model, 88
- knowledge integration, 158(*tab.12.1*), 159, 160
- labour, scarcity of, 4
- Labour government, 48
- labour market, 9–10
- law, 12–13

- leadership, implementation of policy, 151
- Ledward, 6
- Local Authority Overview and Scrutiny Committee, 21
- local medical committees, 6
- management, 78, 148–50
- Management in Government Program, 93
- managerial capacity, 51, 52
- managerialism, 93
- managerial logic (GPs), 215, 220
- managers, critical, 151
- marketing, 53
- quality, 196–9
- regression model, 203, 203(*tab.15.2*)
- study design/results, 196–204
- marketization, 145
- medical audit, 5, 8, 218
- medical dominance, 187
- medical managers, 9, 14
- medical practice (transparency in), 7
- medical work control
- GPs, 213–19
- models of, 210–3
- mergers, 37–8, 64, 65, 70
- Milburn, A., 48
- modelling tools, decision making, 22
- models of care, 161, 162
- moderating factors, health specific, 69
- Modernisation Agency (NHS), 113–14, 182, 189, 218
- modernisation agenda, 91
- Modernisation Project, the NHS, 88
- modern moderating, 69
- Monitor, 47, 53
- monitoring, 54
- MOST (Method Oriented Safety Thinking), 104
- National Cancer Institute (Canada), 156
- National Clinical Assessment Authority, 218
- national framework for the assessment of performance, 218
- National Institute for Improvement and Innovation, 182
- National Institute of Clinical Excellence, 7, 181, 218
- National Service Frameworks, 7, 182, 190, 218
- negotiated order, 5
- neo-institutional theory, 34–5, 36, 41, 42
- New Labour, 2, 9, 112
- new public management, 7, 209
- NHS Act, 1997, 12–13
- NHS Direct, 11
- NHS Informatics Programme, 8
- NHS Plan, 48–9, 113
- NHS plc*, 94
- NHS Plus, 11
- NHS reforms, 112
- NHS Service Delivery and Organization Programme, 81, 112
- NHS Service Delivery and Organization R and D Programme of Research on Organizational Form and Function, 59
- NIHR Service Delivery and Organisation Programme, 22
- nurse practitioners, 167, 170, 177
- nurse practitioners,
- institutionalization
- study design, 170–1
- nursing aides (USA), 99, 102, 103, 108
- nursing home industry, 100
- nursing homes (USA), 101, 103–5
- occupational stressors, 103
- OFSTED, 54
- opinion leaders, 190–1
- organisational structures, 35
- organizational climate, 100
- organizational size, 59, 63–5, 66
- literature review, 67–9, 67(*tab.5.2*), 68(*tab.5.3*)
- organizational structure, 59, 66, 70
- OSCAR data, 198, 200
- out-of-hours services, 10
- P45 targets, 54
- partnership working (UK), 139, 142, 143
- study design, 139–42
- Patient Choice, 21, 50–1, 52, 53, 120

- patient satisfaction (hospital mergers), 64
- payment by results, 21, 120
- performance, 55
- indicators, 54, 209, 217–18, 218
 - levers, 59
 - management, 51, 92
 - organizational factors, 60, 60(fig.5.1), 70
 - poor, 8
 - and reconfiguration/restructuring, 28, 40
- Personal Medical Services, 217
- persuasion, 6
- persuasion strategies, long term, 174–6
- Pfeffer, J., 76, 77
- PHASE in Healthcare Research Project, 99
- pluralism, 22, 30
- PMS contract, 12
- policy
- analysis, 87
 - contradictory/divergent, 120, 146–8
 - depoliticizing, 54
 - and discourse, 143–8, 150
 - dissemination/implementation, 143–4, 189
 - evidence-based health care, 181
 - partnership working (UK), 143
- policy changes, 46–50
- effect of (Australia), 39
- policy making models, 88–92
- policy making styles, 94
- political model, 88–9
- politics (and power), 78
- Pollock, Professor, A., 94
- post-bureaucratic control (work), 212–13, 220
- power (cont.)
- and politics, 78
 - positional, 1, 2, 15
 - relationship to technology, 10, 11
- power, 1, 3, 4, 7, 124–5
- balance of, 14–15
 - institutionalization of authority, 6
 - and knowledge, 7, 76, 144
 - occupational group's, 9–10, 187
 - organizational, 15 of PCTs, 217
- power-knowledge, 7
- practice-based commissioning, 55
- primary care
- models of (Canada), 162
 - new providers, 13
 - reforms, 1
 - research, 161
- primary care clinics, 11
- Primary Care Groups, 6, 216
- Primary Care Trusts, 2, 6, 65, 216–17
- primary health care redesign (Canada), 160–2
- private finance initiative, 94
- private sector, 53
- privatization (as decentralization), 53
- professional logic (GPs), 213–14, 220
- public consultation, 21
- see also* public involvement
- public health, 91, 154–5
- public involvement, 146
- criteria for, 125
 - decision making, effects on, 132–4
 - deliberative processes, 135
 - effectiveness, 123
 - evaluation of (Canada), 128–32
 - initiatives resulting from, 133
 - literature, 124–5
 - methods, 125–6
 - national/local processes (Canada), 126, 128, 129(*tab.10.1*), 132
 - policy / decision making, 123, 124
 - study design (Canada), 126–8
 - success criteria, 131–2
 - successful processes, 134
- public participation
- see* public involvement
- Quality and Outcomes Framework, 6, 12, 217
- quality assurance (general practice), 218–19
- quality feedback practices, 204
- quality information, use of, 205–6
- quality measures (nursing homes), 199–200
- quality of services, 51, 100, 194–5

- quality standards, clinical, 8
- quality strategy measures (nursing homes), 198–9

- R&D strategy (NHS), 181
- racism (nursing homes), 104
- rapid rebuttal unit, 94
- rationalisation (hospitals), 19
- (re-)centralization, 47, 51
 - see also* centralization
- reconfiguration, 19–21, 24–8
- reform, organizational, 14
- reform fatigue, 54
- reforms, primary care, 1
- regulation, 12–13, 51, 53, 194, 218
- research
 - application models, 159(*tab.12.2*)
 - cancer, 156
 - evaluative, 112
 - funding, 96, 97
 - multi-voice, 139
 - organizational, study design, 60–3
 - policy process (discomforts), 92
 - primary care, 161
 - to policy and practice cycle, 157
 - unwelcome (to government), 93, 94, 96
- Research Assessment Exercise, 89–90
- resistance (and power), 5
- responsiveness (and decentralization), 50–1
- restructuring
 - Australian teaching hospitals, 38–43
 - for cost containment, 102, 106, 108
 - and efficiency, 38, 43
 - results of, 33
 - theory, 34–6
- retrenchment (hospitals), 19
- revolving door, 48
- Rousseau, D., 76, 77
- Rundall, T., 79

- safety climate, 100–1
- Salaman, G., 81
- SARFIT model, 35–6

- scorecards, public, 195
- Scott, T. et al., 79
- self-regulation, 8
- Service Employees International Union, 108
- Shifting the balance of power, 49
- Shipman, H., 6
- skill-mix, 11, 13
- spending cuts, healthcare, 102–3
- staffing levels (USA), 108
- stakeholder analysis, 22, 23
- stakeholder involvement, 30, 37
- stakeholder survey (organizational structure), 65–7
- star ratings, 54
- Strategic Health Authorities, 65
- structural change, desired outcomes of, 65
- structural contingency theory, 35–6, 36–7
- Sure Start, 95, 96, 142
 - user involvement, 146–7
- surveys, patient, 8
- Sutherland, K., 82
- Sutton, R., 76, 77
- systems models, 159
- systems thinking, 155, 156, 160

- Tamara story, 141
- tariffs, 120
- teaching hospitals (Australia), restructuring, 38–43
- technocratic government, 91
- technocratic solutions, 31
- technological changes, medical, 4
- technological innovation, 69
- technological solutions, 80
- Thatcher government, 2, 14
- third-way policies, 2–3
- total quality management, 213
- training, safety (USA), 104
- transdisciplinary approaches, 155–6, 160
- transdisciplinary knowledge base, 154
- transformation, second order, 113
- treatment centre programme, 113–14
 - evaluation project, 114–20

- treatment centres (NHS),
112, 120
- user involvement, *see* public
involvement
- US National Institute for Occupational
Safety and Health, 99
- values, espoused, 106
- violence, workplace (nursing homes,
USA), 103–5
- walk-in centres, 11
- Walshe, K., 79
- Wanless, D., 93
- Weber, M., 1, 5, 212
- 'what matters is what works', 90
- wicked issues, 90
- Wildavsky, A, 87, 89, 91, 96
- Willmott, H., 80
- work control models, typology,
211(*tab.16.1*)