STRUCTURAL INTERESTS IN HEALTH CARE: ‘REFORMING’ THE UK MEDICAL PROFESSION

Stephen Harrison
University of Leeds, UK

Contact details
Dr Steve Harrison
Reader in Health Policy and Politics
University of Leeds
Nuffield Institute for Health
71/75 Clarendon Road
Leeds LS2 9PL
UK

Direct phone 0113 233 6983
Secretary 0113 233 6905
Home 01484 844055
Fax 0113 233 6951
Email s.r.harrison@leeds.ac.uk

Acknowledgements
This paper would not have been possible without the award to the author by the University of Manchester of a Hallsworth Research Fellowship in the Department of Government during 1997-98. The analysis has benefitted from numerous discussions with Bruce Wood.
1. Introduction
The terms ‘success’ and ‘failure’ have rationalistic overtones; their usage is relative to the intention of an identifiable actor. Yet there is a substantial strand in the literature of policy analysis which at least questions whether such a perspective is ever capable of approaching the complexity of real-world policy making and implementation. Irrespective of such generalities, the specific case which is described cannot be straightforwardly interpreted as an intention to reform the UK medical profession in a specific way. There has been a succession of policy measures, by a succession of governments, begun for a variety of reasons including the trivial and accidental; it is ‘a chain of successive policy choices made up to the present’ (Lindblom 1959 p88). This does not prevent the identification of an underlying agenda for these reform attempts; in this case that agenda is cost containment (Harrison and Moran, forthcoming). Nevertheless, no UK government has made this agenda explicit and some have gone to great rhetorical lengths to deny it (Harrison and Hunter 1994; Harrison and Ferguson, forthcoming), and it is only since the election in 1997 of the first Labour government for eighteen years that the language of reform (the term ‘modernise’) has been used specifically in relation to the medical profession as opposed to the NHS in general.

It is important therefore to be clear that the analysis which follows rests significantly on an ‘ideal-regarding’ (rather than ‘want-regarding’) concept of actors’ agendas and interests (Fishkin 1979). The content of ‘reform’ thus cannot be specified in terms employed by the actors themselves; rather it must be specified by the analyst. In this paper, ‘successful reform of the medical profession’ is taken to mean a significant reduction in what Alford (1975) has termed the ‘professional monopoly’ of doctors.

2. Actors and ‘structural interests’ in the British health care context
Almost 25 years ago, the American political sociologist Robert Alford published his study of health care politics in New York (Alford 1975), in which he introduced the concept of ‘structural interests’. These were to be defined in terms of the extent to which their ‘interests [are] served or not served by the way in which they “fit” into the basic logic and principles by which the institutions of society operate.’ Three types of structural interest were distinguished. Dominant structural interests were those ‘served by the structure of social, economic and political institutions as they exist at any given time. Precisely because of this, [they] do not continuously have to organise and act to defend their interests.’ Challenging interests were ‘those being created by the changing structure of society’, whilst repressed interests were ‘the opposite of the dominant ones.... the nature of institutions guarantees that they will not be served unless extraordinary political energies are mobilised’ (p14, emphasis original).

---

1 This literature occupies a spectrum running from the recognition that problems do not arrive predefined on the governmental agenda (Kingdon 1984), through the notion that policy and action cannot be distinguished analytically (Barrett and Fudge 1981), to complete non-rationality (Cohen et al 1972).

2 Strictly, the United Kingdom has not one National Health Service (NHS) but four: one for each constituent country. Though in practice health policy tends to be led from England, there are some important differences of organisation and many differences in terminology. For simplicity, all terminology employed in this paper relates to England, though the general thrust of the analysis is valid for the UK.

3 It follows that the term ‘reform’ as used in this paper has no normative content.
Structural interests thus were to be distinguished from pressure groups which organise to represent their interests, and the possibility of conflict within a structural interest was not ruled out.

In the context of New York in the early 1970s, Alford identified the dominant interest as the professional monopolists: ‘medicine is a classic case of social organisation of production but the private appropriation of powers and benefits. [It] has maintained control of the supply of physicians, the distribution and cost of services and the rules governing hospitals’ (p14). However, the dominant interest was currently under challenge from the corporate rationalisers, created by ‘changing technology and division of labour in health care production and distribution, and the shifting rewards to social groups and classes. Bureaucratic organisations, mainly the hospitals, are the principal agents potentially available to organise this complex technology.... Hospital administrators, medical schools [and] government health planners.... share a common relationship to the underlying changes in the technology and organisation of health care. This.... generates their developing structural interest in breaking the monopoly of physicians over the production and distribution of health care’ (p15).

Although it is far from self-evidently applicable to the UK (North 1995), Alford’s schema has been influential as a fairly crude heuristic in brief textbook analyses (mainly by political scientists) of possible shifts in the power relationships between doctors and NHS managers (see, for instance, Baggott 1998; Allsop 1995; Mohan 1995; Ham 1992; Harrison et al 1990). This paper attempts a more systematic examination of that question over the period 1982 to date; the following subsections provide pre-1982 background concerning, respectively, the state’s relationship to the NHS, the UK medical profession, and NHS management.

The state and health care in Britain

The tax-financed NHS, introduced in 1948, currently accounts for some 85 percent of UK health care expenditure (or about 5.9 percent of gross domestic product) despite the uneven growth of private insurance since the 1970s (Office of Health Economics 1997). UK citizens have formal access to a comprehensive range of services (mainly without user charges), though legally the NHS is founded on a central government duty to provide services rather than on citizen rights to receive them. This enables governments to ‘cash-limit’ (ie cap) the annual NHS budget; total UK health expenditure thus remains at 6.7 percent of GDP, modest by the standard of OECD comparators. Yet public preferences, at least as revealed by opinion polls, are for more health expenditure; a time series of polls from 1984 to 1990 never shows less than 47 percent of respondents identifying health as their ‘first priority for additional government spending’, with the second-ranked preference (education) never securing

---

4 Repressed interests were the community population, including poor people and members of the middle class with incomes marginally too high to qualify for state-funded medical care. There is an un concealed normative strand to Alford’s analysis, which owed a good deal to contemporary elite theories.

5 Although the rationalisers in the UK context are not ‘corporate’ in Alford’s sense, that is members of commercial corporations, the term has been retained in this paper both for clarity and because, in NHS management jargon, ‘corporate’ is employed to refer to the institution which employs the speaker.

6 A number of heads of the NHS budget remain uncapped, but the number and value of these has been sharply reduced in recent years.
more than 27 percent of responses (Jowell et al 1995). The NHS is the most popular sector of the UK welfare state, and perhaps of government endeavour more generally. Despite initial Conservative opposition to the precise form taken by the NHS in 1948 (Webster 1998), successive governments since that time have been well aware of the political capital to be made or lost in their handling of it (Klein 1983).

The continued development of new medical technologies and the continued ageing of the population have added to the pressure of rising demand to be expected in any system of third party payment for health care (Harrison and Moran, forthcoming). Since the 1970s, governments of both main parties have faced this rising demand alongside the economic pressures resulting from the end of the ‘long boom’ in the postwar West (Moran 1990) with a macroeconomic orthodoxy in favour of reducing public expenditure (Donaldson and Farquhar 1988). This is not to imply that determinism is at work here; there is no simple relationship between (for instance) fluctuations in the UK budget deficit and the measures chosen to match supply of and demand for health care. Controlling medical professionals through rationalisation of their work is certainly one such measure which might be chosen, but numerous other approaches exist and indeed have co-existed with it (Harrison and Pollitt 1994; Harrison and Moran, forthcoming).

The state and the medical profession in Britain

There have always been conflicts within British medicine or between the state and medicine, not least at the creation of the NHS in the 1940s (Webster 1998). At times since then, there has been considerable tension between specialists and junior doctors in training (Harrison et al 1990 ch4) and between specialists and general practitioners (GPs), whilst doctors’ pay has been a source recurring friction with governments (Seifert 1992). Nevertheless, there are several features of the medical profession\(^8\) in Britain that can be employed to support the claim that (in Alford’s terms) it is an interest ‘served by the structure of social, economic and political institutions as they exist at [a] given time’. One such feature is the pervasiveness of the so-called ‘medical model’, that is the view that ill-health equals individual pathology, and that medical interventions are individual ones. It is clear that such an ideology did not simply occur autonomously; Colwill (1998) has shown how the possibility of an NHS centred upon a broader public health approach was rejected in the early 1940s by medical interests in alliance with civil servants.

A second such feature is the close corporatist relationship between the profession as embodied in the British Medical Association (BMA) and medical Royal Colleges, and the Department of Health\(^9\). At national level, this resulted in workforce planning practices very much in the profession’s interests (Harrison 1981; Harrison et al 1990, ch.4; see also Groenewegan and Calnan 1995; Doehler 1989) as well as parallel

\(^7\) Other poll evidence is consistent with this.

\(^8\) This paper does not attempt a contribution to the theory of professions (as opposed to any other sort of occupation); see Friedson (1983 pp25-6).

\(^9\) In 1988 the Department of Health and Social Security had its functions divided, the NHS becoming the responsibility of the new Department of Health. For simplicity, the latter term is used throughout this paper, even where strictly anachronistic.
medical administrative hierarchies within the Department\textsuperscript{10}. The impact of this relationship has however been at least as great at local level, since many aspects of the NHS’s formal organisation have long been constructed in a way which serves medical interests. Thus, GPs have the status of self-employed business persons under a rather vaguely-worded contract for services to the NHS; ‘A doctor shall render to his (sic) patients all necessary and appropriate personal medical services of the kind usually provided by general medical practitioners’ (Ellis and Chisholm 1993, p12). Until 1991 GPs were entitled to refer patients to any specialist in any hospital anywhere in the UK, and (subject to administrative intervention in only the most extreme cases) to prescribe from the pharmacopoeia in whatever quantities they chose. Until 1984 doctors (especially hospital specialists) dominated the management of the NHS, not in the sense of being formally responsible for it, but in the sense of having an entrenched and effective veto. Thus until 1974 the local statutory bodies which ran the NHS had large numbers of doctors in membership (Ham 1981), after which (until 1984) the local NHS was managed by multidisciplinary consensus decision making teams in which doctors, each with the power of veto, held half the membership (Harrison 1982). Until the 1990s, consultants’ (specialists’) contracts of employment were carefully insulated from managerial discretion by being held at the regional, rather than operational level of organisation and included a number of unilaterally exercisable rights, including private practice and appeal to the Secretary of State against dismissal. A proportion of hospital specialists was able to receive substantial ‘distinction awards’ in addition to their salary; these awards were unilaterally, and secretly determined within the profession.

Third, commitment to clinical autonomy\textsuperscript{11} for doctors figured prominently in the official pronouncements of governments from before the creation of the NHS until the 1980s. The wartime coalition government’s 1944 White Paper stated that ‘whatever the organisation, the doctors taking part must remain free to direct their clinical knowledge and personal skill for the benefit of their patients in the way which they feel to be best’ (Ministry of Health, 1944). These sentiments were subsequently echoed on several occasions by Aneurin Bevan, the Minister of Health who presided over the inception of the NHS (Allsop 1995; Watkin 1975). The same view was manifest by both main political parties in the preparations for the first reorganisation of the NHS in 1974; Labour policy was that ‘the Service should provide full clinical freedom to the doctors working in it’ (DHSS 1970), whilst the Conservative line specified that ‘professional workers will retain their clinical freedom.....to do as they think best for their patients’ (DHSS 1972a), noting in a subsequent document that ‘management plays only a subsidiary part.....[it] can help or hinder the people who play the primary part’ (DHSS 1972b). In 1979 it was stated (by the then newly-elected Conservative Government) that ‘It is doctors.... who provide the care and cure of patients and promote the health of the people. It is the purpose of management to support them....’ (DHSS and Welsh Office, 1979, pp.1-2).

\textsuperscript{10}Mrs Thatcher notoriously regarded the so-called ‘learned professions’ of law and medicine as indistinguishable from trades unions, so that this relationship came under considerable strain during the 1980s.

\textsuperscript{11}In this paper, clinical autonomy refers broadly to freedom to accept patients, control over diagnosis and treatment, control over evaluation of care and control over other professions (Schulz and Harrison 1986). It therefore implies considerable freedom from being managed.
**NHS managers**

The practice of management in the NHS over the period until the late 1980s has been likened to the practice of diplomacy. Rather than conforming to the stereotype of an authoritative individual, rationally pursuing organisational objectives by means of proactively-generated change, the NHS manager\(^\text{12}\) possessed little influence relative to doctors, was very much focused on responding to the demands of internal organisational actors, and procured only incremental change. A summary of the evidence from some twenty-five research studies conducted up to 1983 concluded that managers neither were, nor were supposed to be, influential with respect to doctors. The quality of management (like the quality of the service itself) was judged by its inputs. Managers in general worked to solve problems and to maintain their organisations rather than to secure major change (Harrison 1988a p51).

On this analysis, it makes little sense to see NHS managers during this period as allied to Alford’s ‘challenging interest’. Indeed, there was really no such challenge until the 1980s, when the reform attempts upon which this paper focuses first began.

**3. Reforming the British medical profession**

In the 1960s and 1970s the prevailing style of policy making in respect of the NHS was consonant with the then received wisdom in other policy sectors. Thus, for instance\(^\text{13}\), the design of the 1974 Reorganisation of the NHS (which resulted in the management arrangements described above) had been carefully developed over a period of several years. The process of its development included extensive consultation via two ‘green papers’ (Ministry of Health 1968; DHSS 1970), both of which discussed organisational design and the various functions of each tier in some detail, and an equally detailed white paper (DHSS 1972a). The reorganisation was preceded by several years of design work by management consultants and academics, which produced rather distinctive formal organisational arrangements (see for instance Rowbottom *et al* 1973; Jaques 1978). The plans which took shape over this period survived changes of government from Labour to Conservative in 1970, and back in January 1974, with only minor changes such as the Conservatives’ even more explicit emphasis on management (Klein 1983 p91) They were promulgated to the NHS in a document which became known as the ‘Grey Book’ (DHSS 1972b), a detailed and densely packed nationally uniform organisational prescription of structures, and institutional, managerial and professional roles and relationships, including elaborate consultative mechanisms and formal powers of veto.

The story told below postdates the above events and extends over nearly twenty years. The period can conveniently be divided into three phases, though in no sense do these events represent any kind of sequential ‘master plan’. On the contrary, they have been characterised by a policy style towards NHS organisation and management which may

---

\(^{12}\) Medically qualified managers in the NHS have always been relatively few, though the actual numbers increased briefly in the mid 1980s (Harrison 1988a) and again in the late 1990s.

\(^{13}\) For a more detailed account of this policy style as applied to the NHS, see Harrison and Wood, forthcoming.
be labelled ‘manipulated emergence’, that is promulation of a series of ‘bright ideas’ accompanied by incentives for local actors to develop them into concrete organisational arrangements consonant with these ideas (Harrison and Wood, forthcoming). For each phase, both the style of policy making and the substance of relevant policy are examined.

**1982-88: the introduction of ‘general management’**

The introduction in 1984 of individual general managers (later ‘chief executives’) in place of the system of consensus team decisionmaking described above was almost accidental (Harrison 1994), and certainly not foreseen when the government attempted in 1982 to commission an inquiry into NHS ‘manpower’. The person offered its chair declined the offer. Ministers and officials did not have an immediate substitute in mind and sought advice from a number of industrial *confidants*; Mr Roy Griffiths, then Managing Director of the Sainsbury supermarket chain, who had no previous contact with government, was proposed and was subsequently offered the role. Griffiths declined, on the ground that if there were problems with the size of the workforce, that was only a symptom of a deeper problem, one of management; he would accept the chair only if the terms of reference were changed to focus upon NHS *management*. The government conceded this. The eventual policy recommendations were radical but also vague; the report (NHS Management Inquiry 1983) took the form of a 24 page, double spaced typescript letter from Griffiths to the Secretary of State and contained only the sketchiest account of the functions of various new institutions. A number of recommended changes within the Department of Health were quickly accepted, leading in due course to the abolition of its parallel medical and administrative hierarchies; the other recommendations became the subject of a consultation exercise.

The proposal to appoint general managers met a good deal of resistance from the medical\(^\text{14}\) profession over a prolonged period; the Chairman of the Council of the British Medical Association wrote to the Secretary of State in the following terms:

> It could be interpreted from the [Griffiths] report that a somewhat autocratic ‘executive’ manager would be appointed with significant delegated powers, who would - in the interests of ‘good management’ - be able to make major decisions against the advice of the profession ... it should be clearly understood that the profession would neither accept nor cooperate with any such arrangement - particularly where the interests of patients are concerned... (quoted in *British Medical Journal* 288, 14 January 1984, p. 165).

This virtual declaration of independence was accompanied by various demands for modifications to Griffiths’ scheme and a trial period for any changes. Despite all this and some diffidence by the Secretary of State, the new arrangements were accepted by the Government when it became clear that they had the Prime Minister’s support. Thus the roles of the new general managers and the shape of local organisational structures were left to emerge.

\(^{14}\) The nursing profession was just as unhappy (Social Services Committee 1984, pp44-8; Harrison 1988b, pp146-9).
Although these reforms clearly offered something of a challenge to clinical autonomy, a review of empirical research carried out between 1984 and 1990 concluded that, despite defeats over the form of the Griffiths innovations, the medical profession had experienced little resulting loss of autonomy (Harrison et al 1992, ch4). These findings correspond to the observation that, so far as doctors were concerned\(^{15}\), the ‘diplomat’ role for managers had not changed much. Three relevant changes did, however, result. First, managers became much more externally focused; they were increasingly compelled to respond to governmental agendas and were consequently less able to respond to internal professional agendas (Flynn 1988). Second, many hospital managers began to develop decentralised budgetary systems and corresponding internal organisational structures which reflected medical workload and (Packwood et al 1991; 1992). Third, by 1985 there was no longer any pressure, in medicine or elsewhere, for a return to consensus team management; general managers had achieved legitimacy if not substantial influence.

**1989-1997: the ‘purchaser/provider split’**
Prior to 1991, the NHS was organised primarily through DHAs whose functions included both the local allocation of health care resources and the actual provision of local services in publicly-owned hospitals, clinics and domiciliary settings. GPs were self-employed contractors to the NHS, remunerated through capitation fees, fees for service and various allowances, and were somewhat insulated from the remainder of the NHS, their contracts being held by separate public bodies. However, they were able to refer their patients freely to NHS hospitals and other services, the financial consequences of such decisions falling upon the hospitals and the DHAs who governed them. Although the early 1980s saw the withdrawal from NHS prescription of a number of preparations, GPs were also able freely to prescribe drugs within the wide ranging NHS pharmacopoeia without financial implications for themselves. The 1991 reorganisation represented a major departure from this by providing an institutional structure radically different from that which preceded it; the policy process by which the purchaser/provider split arrived also differed from what had gone before.

Like the Griffiths Report that preceded it, there were elements of accident in the inception of the Prime Ministerial Review of the NHS, which led in turn to the purchaser/provider split\(^{16}\). This review was the product of widespread concern about the level of NHS funding during the second half of 1987. This reflected the disappointment of health authorities at their budget allocations and decisions by several major interest groups\(^{17}\) to commence their own enquiries into NHS funding. The same concerns came to be reflected in Parliament, especially after substantial media coverage had been given to reports of delays in urgently needed treatment of some children’s cardiac conditions. The predominant mood was crystallised at the end of the year in a statement by the presidents of the Royal Colleges of Physicians, Surgeons, and

---

\(^{15}\) This did not apply to the occupations other than medicine, which experienced a loss of autonomy in relation to NHS managers. One study (Pettigrew et al 1992) did indicate a degree of increasing management control over medicine; for a discussion of this apparent discrepancy, see Harrison et al (1992 p86).

\(^{16}\) For a more detailed account, see Harrison (1994 pp 92-5).

\(^{17}\) The King’s Fund Institute, the National Association of Health Authorities, and a combination of the BMA, Royal College of Nursing and Institute of Health Services Management.
Obstetricians and Gynaecologists, calling in the strongest language for more funds (Leathard 1990 p129). Despite early indications that the government was prepared to ‘tough it out’ even to the point of a media battle with the BMA, the Prime Minister (without having previously informed Parliament) announced on television that a review of NHS funding would be conducted. Although the review had been established in response to issues about the amount of NHS funding, media analysts were quick to assume that funding methods would be the prime focus; in the event the recommendations were for yet another reorganisation, into what became called the ‘purchaser/ provider split’ (see below). As with the Griffiths reforms, the government faced a good deal of opposition from the BMA:

[BMA Council] does not believe ... that the changes proposed would achieve [the government’s stated] aims. Indeed, it is convinced that many of the proposals would cause serious damage to NHS patient care, lead to a fragmented service and destroy the comprehensive nature of the existing service. The Government’s main proposals would appear to be to contain and reduce the level of public expenditure devoted to health care. The proposals would undoubtedly increase substantially the administrative and accountancy costs of the service, and they ignore the rising costs of providing services for the elderly and of medical advances. In the absence of any additional funding the proposals would inevitably reduce the standards of NHS patient care (British Medical Association 1989 p2).

By mid 1989 there was a widespread perception that the government was losing political ground on the issue, circumstantial evidence of which continued to be apparent in opinion polls throughout 1990 and 1991, but the government persisted with the necessary legislation, and in June 1992 the BMA formally ended its campaign against the changes.

The process by which the new arrangements emerged can be described as representing a shift from policy based on blueprint (which characterised the 1960s and 1970s, exemplified by the 1974 Reorganisation discussed above) to policy based on bright idea (Harrison and Wood, forthcoming): a deliberate eschewing of blueprints in favour of the promulgation, in vague terms, of a core set of ideas combined with an invitation to relevant actors (which they could not easily refuse) to constitute the formal institutions which would embody these ideas. The key characteristics of the new process were as follows. First, the process of initial design of the reforms was short and closed. The review which led to the reorganisation was conducted informally, largely in secret and uninformed by expert opinion from the field (Lee-Potter 1997), all but one of the review team members being politicians. Second, the white paper Working for Patients (Secretaries of State 1989) contained only the barest account of the purchaser/ provider split and the roles of its key institutions (see below). It promised further details in a forthcoming series of working papers on organisational and financial matters. As Klein has summarised it ‘the white paper’s proposals were little more than outline sketches, even when supplemented by a series of working papers’ (1995 p198).

Third, even by the formal implementation date of April 1991 aspects of the reorganisation fundamental to the purchaser/ provider split, not least the contracting
process, had not been thought through. Relationships between institutions were adapted as perceived to be necessary and some of these amounted to far more than minor adjustments in government thinking; for instance the relative importance given to competition and cooperation, the importance of GP fundholding rather than health authority purchasing, and the ideal service configuration for Trusts (that is, whether acute and non-acute services should be combined in one institution) all varied substantially between 1991 and 1996. Finally, the implementation arrangements for the new organisation structure were not uniform, but rather centred upon a process of annual waves of volunteers for reformed status. The criteria for admission of volunteers to this were developed in parallel with the application process. This allowed ongoing adjustments; thus initial criteria for acceptance of volunteers were relaxed over time to ensure the apparent success in implementation terms of the approach. Indeed, there were incentives for managers and senior professionals not only to acquiesce in the innovations, but to volunteer to participate in their development; for instance, Trusts were freed from a number of policy constraints, including national pay scales,\(^{18}\) and might aspire to accumulate financial surpluses with which to develop services\(^ {19}\). It is such incentives that underpin the description of the process as ‘manipulated emergence’ (Harrison and Wood, forthcoming).

In substance, the purchaser/provider split took two, not entirely compatible forms, DHA purchasing and GP Fundholding (GPFH), both centred on the notion that the actual provision of services should be the function of NHS Trusts, independent of direct DHA control, but in a quasi-contractual relationship with both them and with GPFHs for the supply of patient services. In the first model of purchasing, DHAs became financially responsible for health care for their geographically-defined resident populations, being expected to purchase this from hospitals and community service providers which progressively attained the status of NHS Trusts. Although GPs remained self-employed, this entailed a potential reduction in their freedom to refer, since referrals normally had to fall within the contractual arrangements made by the patient’s home DHA. Empirical evidence about the outcomes of DHA purchasing (Flynn and Williams 1997; Robinson and Le Grand 1993) attributes little impact to any provider competition that may have occurred, but it seems likely that the possibility of such competition helped to change medical/managerial relationships within hospitals (Harrison and Wistow 1992; Harrison and Pollitt 1994 ch5). Thus cost pressures and the necessity to calculate the price of services made medical activity more transparent, whilst the newly-acquired mutual interests of managers and doctors in ensuring the survival and prosperity of their institution rendered unwise any medical strategy which ignored institutional interests. Moreover, doctors’ employment contracts were now held locally by the Trust, and their rights publicly to criticise developments in the NHS thus somewhat curtailed; they subsequently lost their rights of appeal to the Secretary of State.

The second model of purchasing owed a clear intellectual debt to the US concept of the health maintenance organisation; like Trust status, GPFH was introduced on a

---

\(^{18}\) However, many senior doctors did oppose their hospitals volunteering for Trust status, but were outmanoeuvred by local managers (Peck 1991).

\(^{19}\) Such aspirations might be disappointed in practice, in some cases with disastrous results for individual institutions (Harrison et al 1994).
voluntary basis and the population coverage of fundholding increased over time as more and more volunteers came forward. By 1996 over 30 percent of general practices were involved (Audit Commission 1996). The central feature of the scheme was the allocation to GPFHs of a budget to purchase specified secondary care services from NHS Trusts or perhaps from the private sector. The specified services were redefined and expanded over time, but the largest components were elective surgery, directly accessed diagnostic and therapeutic services (such as pathology, radiology and physiotherapy), most specialist outpatient services, and (within certain restrictions) domiciliary nursing. GPFHs also received a prescribing budget and one for ancillary staffing; although these three budgets were calculated and allocated separately, GPFHs were able to reallocate (‘vire’) money between them. The greater freedoms of GPFHs were themselves an incentive to participate, as was the provision that budget underspendings could be retained for reinvestment in the business. Empirical evidence about the impact of GPFH has been reviewed by several authors (Petchey 1995; Dixon and Glennerster 1995; Harrison and Choudhry 1996; Goodwin 1996). The actual impact of fundholding on referral behaviour, prescribing and relationships with patients is unclear, but there is quite strong qualitative evidence that GPFHs were willing and able to shift some specialist clinics into a primary care setting. It also seems clear that GP fundholding led to changed relationships with Trust providers and therefore with hospital specialists. Threats to reallocate referrals led to concessions in terms of such matters as turnround of pathology results, prompter patient discharge reporting and the reduction of waiting lists.

New Labour and NHS organisation: 1997 to date

Despite the publication, whilst still in opposition, of two ostensibly weighty policy documents concerning NHS policy (Labour Party 1994; 1995), there is little evidence of any serious policy development (Macaskill 1998) until some six months before the last possible date for a general election, when the then shadow health spokesman gave an unusually detailed speech about the future of primary care organisation (Smith 1996). After its massive election victory of May 1997, so-called New Labour’s initial NHS reform proposals appeared in a white paper The New NHS: Modern, Dependable (Secretary of State for Health 1997) which, despite its bulk is quite insubstantial. Considerable repetition of central ideas is accompanied by only the sketchiest details of key institutions and processes such as the management of the new Primary Care Groups, the proposed National Institute for Clinical Excellence, the development of local systems of ‘clinical governance’, arrangements for integrating with the work of local authorities, and funding for patients who receive care outside their home district. The retention of NHS Trusts is an implicit acknowledgement of the success of some of the Conservatives’ reforms, and the phrase ‘go(ing) with the grain’ of trends recurs frequently.

Three of the key elements of the ‘bright idea’ approach practised by the Conservative administration in respect of 1991 reorganisation initially applied to Labour policy. The White Paper was developed in a secret process and gave only bare details of policy but largely abandoned the fourth element, that is the strategy of implementation by

---

20 It seems plausible that such forbearance from health policy making reflected an electoral calculation; since opinion polls made it clear that Labour had overwhelming public approval in this sector, policy represented a hostage to fortune.
volunteers, underpinned by material incentives. Subsequently published instructions, however, have had an altogether more ‘top-down’ flavour, as can be seen in the specificity of both policy content and intended policy outcomes. The content of policy handed down to the NHS has become more specific, with less scope for NHS actors to shape it for themselves. For instance, PCG membership (unlike GPFH status) is compulsory, albeit with some initial choice of entry conditions, and much of the apparatus of clinical governance is built round national institutions with centrally-determined functions. It is ironic that the term ‘governance’, normally employed in the discourse of academic politics to signify a mode of co-ordination based on networks rather than on hierarchy (Rhodes 1996) has been officially appropriated to refer to a set of rather hierarchical arrangements for controlling members of the medical profession. In substance, the three main elements of new Labour health policy as it affects the medical profession are ‘clinical governance’, the creation of Primary Care Groups (PCGs) and a number of initiatives aimed at recognising the potential contribution to population health of factors other than medical services.

A consultation document A First Class Service: Quality in the New NHS (NHS Executive 1998) was issued some seven months after the original white paper. This is another physically substantial document, which does move nearer to providing a blueprint for certain aspects of NHS organisation policy than has been the case since 1974. Clinical governance is there defined as

> a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (NHS Executive 1998 p33).

This formulation is perhaps calculated to be anodyne; in any event, it conveys little of substance. In some respects it builds on developments which took place under the previous government, specifically the appearance of an NHS Research and Development strategy (Baker and Kirk 1996) linked to so-called ‘evidence-based medicine’, the normative doctrine that professional clinical practice ought to be based upon sound biomedical research evidence about the effectiveness of each diagnostic or therapeutic procedure (Harrison 1998a p15), promulgated to professionals via ‘clinical guidelines’21. Under the Conservatives, attempts to implement such policy rested mainly on exhortation; Labour policy is much more vigorous. The three new institutions of clinical governance will be the National Institute for Clinical Excellence (NICE), the Department of Health’s programme of ‘National Service Frameworks’ (NSFs), and the Commission for Health Improvement (CHI).

NICE will be established in 1999 with the role of undertaking 30 to 50 evidence-based appraisals per annum of new or existing clinical interventions (such as drug treatments, surgical procedures or physiotherapy treatments), at least some of which are likely to be subcontracted to existing academic centres with relevant expertise. Such appraisals may result in the production of clinical guidelines for the management of relevant medical conditions, or in recommendations to the Department of Health that particular treatments should not be introduced to the NHS without further trials. It

---

21 For an account of the development of this policy, see Harrison (1998b).
is made clear that such appraisals will include evidence of cost-effectiveness as well as clinical effectiveness. NICE will also be responsible for giving its imprimateur to particular models of clinical audit for use in hospitals. In addition to this central specification by NICE of clinical models, there is to be central specification of service models, beginning with coronary heart disease and mental health. NSFs will be developed as a means of defining the pathway through primary, secondary and tertiary care which a particular type of patient will be expected to pass. Although developed in consultation with experts and consumers, NSFs will be nationally promulgated by the Department of Health, and compliance will be a dimension of NHS performance management. Third, CHI will be established as a statutory body ‘at arm’s length from government’ (NHS Executive 1998 p51) and will ‘conduct a rolling programme of reviews, visiting every.... Trust over a period of around 3-4 years’ (p53). Such reviews will include local compliance with clinical guidelines issued by NICE, and with NSFs. In addition to routine reviews, the NHS management hierarchy will be able to initiate inquiries where local problems are suspected.

Chief Executives of Trusts will become responsible for the clinical, as well as the financial performance of their institutions and new legislation will place upon Trusts a statutory duty for the quality of care. This is likely to provide a managerial motivation to respond to the activities of the new institutions described above (Black 1998). For each NICE guideline, a local ‘lead clinician’ will be identified as having responsibility for leading local implementation and departures from NICE recommendations will ‘be challenged locally’ (NHS Executive 1998 p22). Although the previous Conservative government decreed that all doctors should take part in medical audit, this was not enforced; however, from 1999 all hospital doctors will be required to participate in national specialty-based audit programmes.

Given the recency of these developments, nothing can be said about their outcome. Yet the proposals have not been strongly resisted by the medical profession; the manner of their reception has been influenced by the media and public response to the discovery that paediatric cardiac surgeons in the city of Bristol had a poor survival record for particular surgical procedures and that attempts by other members of staff to draw attention to this had been obstructed in various ways (Klein 1998). In 1998 three doctors, including the hospital’s medically qualified chief executive, were dismissed and two of them were disqualified by the General Medical Council from the further practice of medicine (Dyer 1998).

In Labour’s second major health policy area, Primary Care Groups (PCGs) will federate groups of general practices so as to produce aggregate practice populations of from 46,000 to 257,000. PCGs may take one of four forms. At level 1, the least developed form, PCGs support the HA in commissioning care for its population, acting in an advisory capacity. At level two, PCGs will take devolved responsibility for managing the budget for health are in their area, formally as part of the HA. At level 3, PCGs become more independent of the HA, and are therefore to be solely accountable for the budget, and from April 2000 PCGs will be able to acquire the status of NHS Trusts (level 4). Where a budget is held, it will be a cash-limited unified budget for providing primary health care and purchasing hospital and community services, though HAs will continue to commission highly specialised services such as transplant surgery.
Unlike GP Fundholding (which is to be abolished), membership of a Primary Care Group (operational from April 1999) will be compulsory for all GPs, and there will be strict rules about the geographical coverage of such groups. PCGs are intended to develop around ‘natural communities’ rather than groups of like-minded GPs. Although the self-employed status of GPs apparently will not change, PCGs will have governing Boards accountable to HAs and required to enter into annual ‘accountability agreements’ with them. There will be a requirement to produce a (public) annual accountability report, presumably relating to the preceding year’s accountability agreement. Whilst there are potential non-material incentives resulting from the proposal of four different entry levels to Primary Care Group status, and some GPs certainly perceive an incentive to achieve the highest level as quickly as possible in order to maximise their independence from the Health Authority, initial GP enthusiasm for PCGs was far from general (Health Service Journal 28 May 1998, p3; 2 July 1998, p11; British Medical Journal 28 March 1998, p1025). The government found it necessary to make a number of concessions, including allowing GPs to occupy a majority of seats on PCG Boards and hence to chair them. Although it appears that GPs have accepted that PCG participation is unavoidable, there remain strong expressions of concern that the new arrangements will offer much less autonomy than old GP fundholding (McIntosh 1998).

Labour’s third policy area consists of initiatives which recognise that services other than medicine, and agencies other than health care providers have a potential contribution to population health. One of these is Health Improvement Programmes, a statutory requirement for all HAs to work with local government authorities, NHS Trusts and PCGs to address local health needs through economic, social and environmental policies in addition to health care services (Secretary of State 1997 pp26-7). Another such initiative, Health Action Zones, allowed NHS institutions to bid for centrally-allocated funds to develop multi-agency programmes to improve the health status of their local populations. None of this work began until 1998 and no outcomes are yet observable.

In addition to these central policy thrusts, Labour has introduced a number of piecemeal changes which bear on the topic of this paper. The committee which allocates distinction awards to senior doctors will lose its medical majority and gain patient representatives in addition to senior NHS managers (Crail 1998) and the government intends to review the provisions of NHS consultants’ employment contracts applying to private medical practice (Moore 1999). The parliamentary Health Service Commissioner may now investigate complaints against GPs, which had previously been excluded from the ambit of the office (Warden 1999). New legislation will allow the government more easily to change the self-regulating status of the health professions (Smith 1998), though it appears that the recent decision by the General Medical Council to work towards a system of compulsory periodic competence accreditation may have pre-empted any immediate government attempt to modify the rules of professional registration (Healy 1999).

22 Such boards are required to contain one or two nurses; members of other clinical professional groups may be co-opted but without voting rights. Only two PCGs are not chaired by GPs; in both cases, nurses occupy the role because no doctor was willing (McIntosh 1999).
4. Assessing success and failure
Assessing the success and/or failure of policy requires two sorts of analysis. The first is the equation or otherwise of the outcome with the apparent intentions of policy makers: programmatic outcomes. In the present case, this is not straightforward. It has been seen that reforming the British medical profession has been more of a sporadic long-term ‘project’ than a programme; moreover, it is a project whose existence is inferred by observers from government actions rather than announced as government intentions. Second, political success or failure is in principle distinguishable from programmatic outcomes; it is possible, as it were, to win the battle whilst losing the war, or vice versa. In the present case, there again are difficulties since political and programmatic outcomes are not clearly distinguishable. If a weakening of medical dominance is the outcome under examination, the fact (or otherwise) of such weakening is itself intimately connected with the distribution or redistribution of legitimacy between government and its agents on the one hand, and the medical profession on the other. The assessment of success or failure must therefore be approached with these qualifications in mind.

Has medical dominance been weakened?
In order to assess the programmatic outcome of the project described in this paper, it is necessary to return to the institutions which were identified above as the basis of professional monopoly in Britain; in Alford’s terms, are medical interests less well served by these that before? The first such institution is the ‘medical model’ of health and illness; it is clear that this is still the pervasive ideological basis of the NHS. Whilst potential challenges exist in the form of new institutions (such as HAZs and Health Improvement Programmes) which are predicated on assumptions that ill-health should be seen partly as a social phenomenon which can be addressed by multi-agency, multiprofessional measures, these are very new and (in the case of HAZs) constructed as pilot initiatives rather than mainstream policy. None has as yet had any impact and indeed the issue which both current government and opposition have chosen to make salient is very much in conformity with the medical: hospital waiting lists. A further manifestation of the present robustness of the medical model is the continued assumption that doctors are the ex officio leaders of clinical teams. Indeed, to the extent that an extended role for primary care providers is core government policy, this assumption has been strengthened; PCGs will be federations of small businesses owned by GPs with rights to majority membership of their controlling board. It remains to be seen whether the accountability of such boards to Health Authorities will in any way modify this professional dominance.

The second institutional source of medical dominance is the corporatist inclusion of the ‘peak associations’ of medicine, particularly the BMA and the medical Royal Colleges, in government decision making about health policy, along with a pervasive influence on local institutions. In contrast to the durability of the medical model, it seems clear that the ‘insider’ role of medicine in government has been weakened. This is observable in the changed position of doctors in the civil service hierarchy, their reduced role on NHS governing bodies (other than the new PCGs) and gradual managerial encroachment on the allocation of distinction awards. Its most obvious manifestation, however, is the series of defeats which the profession has incurred with respect to NHS organisation. It resisted the introduction of both general managers and
the purchaser/provider split, and the latter can be interpreted as government retaliation for professional temerity in the form of the Royal College presidents’ demands for more NHS resources. In the classic neo-corporatist account of liberal democracies (Schmitter 1974 p96) the medical profession is a state-licensed elite which has been granted a representational monopoly in return for observing certain controls on the behaviour of its members. One interpretation of the events described here is that a state may be strong enough to terminate a corporatist relationship which is not seen to be delivering the required controls of the rank and file.

The third institutional source of medical dominance is the professional autonomy of individual clinicians. Although there is little evidence that the 1984 reforms had a direct effect on medical-managerial power relationships, they did legitimise the existence of a new breed of chief executives. These became further entrenched as a result of two aspects of the 1991 reforms; not only did the possibility of competition between Trusts create an incentive for doctors to collaborate with managers in order to manage their new organisational environment, but medical conditions of employment were changed so that doctors became Trust employees. There is little evidence of this increased managerial influence affecting the narrower aspects of clinical practice, except in relation to GP fundholding. As noted above, fundholders were able to employ their new financial influence to change some aspects of the behaviour of hospital specialists; it is likely that much of this influence was applied via Trust managers. At the same time, non-fundholding GPs lost some of their freedom of referral of patients. It is clearly too early to expect any impact from the latest (post-1997) reforms, but their form presents a clear challenge to medical autonomy; the model of a national body (NICE) formulating clinical guidelines for local implementation, accompanied by an inspectorate (CHI) and a set of clear managerial incentives for institutional compliance, can only be described as neo-bureaucracy, a bureaucracy which is rather different from the ‘professional bureaucracy’ (Mintzberg 1979) in which bureaucratic rules on non-professional matters co-exist with professional autonomy.

Political outcomes
Despite the political popularity of the NHS, and the high level of occupational esteem accorded to doctors (Harrison 1988), governments have successfully weakened professional dominance without this of itself having adverse political consequences. Some of the means employed to do so have, however damaged the government’s own legitimacy; it is clear, for instance, that the purchaser/split had little public support and this may have contributed to the size of the Conservatives’ 1997 election defeat. It is not yet clear whether the means adopted by the new Labour government will have such adverse consequences. Underlying its strategy are the apparently commonsense propositions that no-one wants ineffective health care (Evans 1990), that the effectiveness of clinical interventions is definitively provided by research employing randomised controlled methods (##Elwood##bib), and that the findings of such research can be implemented by disseminating clinical guidelines to doctors. Yet all these assumptions are challengeable on empirical grounds (Harrison 1998a), that is, the relevant actors may not accept them. The first proposition is only valid if there is agreement about what level of probability is held to constitute ‘effective’. The second is not the only epistemology to which reasonable doctors might adhere (Tanenbaum 1994), whilst the third is commonly criticised as ‘cookbook medicine’(Parmley 1994).
Moreover, it now seems that NICE will operate on a criterion of cost-effectiveness (Health Services Journal, 4 February 1999), which is less likely to seem a publicly acceptable criterion for rationing new drugs such as Beta-Interferon or Viagra.

5. Explaining the outcome
Given the period over which the reform attempts described above have been spread, it is hardly surprising that no single line of explanation\(^{23}\) for the outcome is plausible. The institutional framework of the NHS within UK government was certainly a key factor in facilitating the outcome. Specifically, the combination of its tax-financed, budget-capped, central government-controlled character with its position as the dominant provider of medical care\(^{24}\) means that (despite ostensible managerial decentralisation and the delivery of services through local institutions) government has levers which would not exist in a more pluralist system. This is not to say that the NHS is a command-and-control system in which the reforms were simply decreed, but rather that there is little by way of an ‘exit’ option (Hirschman 1970) for doctors. As has been noted, the medical profession was ready enough to employ the alternative option of ‘voice’; central government’s answer to this was indeed to use its extensive powers to introduce the reforms in a formal sense. But the formal existence of a policy does not constitute its implementation (Hogwood and Gunn 1984), and it is in this respect that the style of policymaking adopted between 1987 and 1997 also made a difference.

In terms of implementation, the strategy of ‘manipulated emergence’ approach adopted the Conservative governments can be seen as highly successful (Harrison and Wood, forthcoming). The absence of a blueprint allowed unannounced policy adjustment to emerge when deemed necessary and blunted potential opposition to the reforms by making it difficult for opponents to seize on concrete proposals to criticise; the volunteer arrangements both allowed time for the reluctant to become used to the idea of the new status (of Trust or Fundholder) and to feel that nothing was compulsory. Most importantly, a ‘bandwagon effect’ was rapidly created. Labour’s approach is increasingly diverging from this model, though again it is too early to assess the impact.

The choice of two specific political tactics can also be identified as having contributed to the government’s weakening of medical dominance. One such tactic has been the exploitation of the historically rather loose coupling between the medical profession as represented by its peak associations and individual practitioners at local level. Until the 1980s, this frequently worked against government, as national agreements were simply not delivered locally (Harrison et al. 1990 ch4), but governments were subsequently to turn this to their own advantage and into a ‘collective action problem’ (Olson 1965) for medicine. Thus ‘manipulated emergence’ was possible because (for instance) some GPs did seek greater influence and with suitable incentives were

\(^{23}\) Evaluations of policy outcomes often give insufficient concern to establishment of the counterfactual: that the outcome would not have occurred without the policy (Pollitt et al. 1990). In the present case, the attribution of the outcome to government action is generally plausible. For instance, there are clear examples of medical resistance having been overcome.

\(^{24}\) The NHS approaches monopsony in respect of the employment of doctors. Although, as noted, the private medical sector represents some 15 ### percent of the whole, virtually all doctors practising in this sector are also NHS employees.
prepared to volunteer for fundholding status and some hospital specialists were
sufficiently frustrated by team consensus decision making to support the appointment of
chief executives or even to take such posts themselves. More recently, governments
have been able to exploit the pre-existing ‘evidence-based medicine’ movement as the
underpinning of the proposed system of clinical governance (Harrison 1988b). A
second tactic which seems to have served governments well is political opportunism.
Thus, the Conservatives succeeded in exploiting (albeit after some delay) Griffiths’
demand for changes in his terms of reference and the public perception of an NHS
funding crisis in 1987. More recently, the Labour government has exploited public
concern over the clinical performance of paediatric cardiac surgeons in a particular
hospital as a justification for clinical governance.

In Alford’s analysis, the manufacture of ‘crises’ is a tactic commonly adopted by
groups ‘seeking to make political capital out of a situation that has existed for many
years and will continue to exist after the “crisis” has disappeared from public view’
(1975 pxi); ‘responses to [these] take the form of symbolically reassuring
investigations, whose reports call for new administrative devices.... (pxiv). For Alford,
the implication is that nothing of substance will result, since such symbolic politics
‘serves simultaneously to provide tangible benefits to various elites and symbolic
benefits to mass publics.... blurring the true allocation of rewards’ (p ix). But in this
case, something of substance has occurred, albeit in the relationship between two
elites. The final section therefore addresses the implications of all this for Alford’s
schema of structural interests.

6. Conclusions: restructuring interests in health care
Although there were attempts from the mid-1960s onwards to draw it into the
management of the NHS, there was little attempt to control the UK medical
profession until the early 1980s. Given the structure of institutions at that time,
medicine could justifiably be regarded as the dominant structural interest and
moreover one which was unchallenged; contemporary research clearly shows the role
of NHS managers to have been subordinate to, and supportive of doctors. The
Griffiths and related changes can be seen as the beginnings of a challenging structural
interest; this period saw both the translation of managers from agents of medicine into
agents of government and the legitimisation of the managerial function. The 1990s, the
period of the purchaser/provider split, created new institutions which served and
strengthened this challenging interest, though without the latter achieving dominance.
This period also created a new interest group, GP fundholders, who were in the
fortunate position of being served both by the pre-existing structures of medicine and
by the new structures of management. The post-1997 institutions are still in the
process of being established and have as yet had no impact. However, it is possible to
identify two crucial directions of development. First, if NICE and the other apparatus
of clinical governance were to function in the way apparently envisaged in official
documents, the corporate rationalisers would have become the dominant structural

25 Alford is here drawing on the formulation of Edelman (1964; 1971), originator of the notion of
‘symbolic politics’.
26 Despite considerable rhetoric of consumerism and public involvement, there is little evidence of
much influence on the part of non-elites (Harrison and Mort 1998).
27 For a detailed history, see Harrison (1988 ch2).
28 Hence North’s (1995) difficulty in incorporating them into Alford’s model.
interest, and will have done so by appropriating the medical model for their own use. Second, since PCGs (as the successors to GP fundholding) will be the most difficult environment in which to implement clinical governance (Abbott et al, forthcoming), the successful development of managerialism in primary care would be another indicator of the dominance of the corporate rationalisers.
References
Edelman M (1971) Politics as Symbolic Action: Mass Arousal and Quiescence, Chicago IL: Markham Publishing
Flynn R (1988) Cutback Management in Health Services, Salford: University of Salford Department of Sociology and Anthropology


Harrison S (1998b) ‘Evidence-based medicine in the NHS: towards the history of a policy’ in R Skelton, V Williamson Fifty Years of the NHS: Continuities and Discontinuities in Health Policy, Brighton: University of Brighton


Ministry of Health and Department of Health for Scotland (1944) A National Health Service, Cmnd 6502, London: HMSO

Ministry of Health (1968) National Health Service: The Administrative Structure of the Medical and Related Services in England and Wales, London: HMSO


Moran M (1990) ‘European health care policy since the end of the long boom’ paper presented at 18th Joint Sessions of the European Consortium for Political Research, Bochun, 2-7 April

22