Power in the health service: the effects of reorganisation on professions and bureaucracies

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Abstract

The National Health Service (NHS) has been analysed predominantly in terms dictated by a systems/functional model of organisational behaviour. Decision-making processes which did not comply with this model were regarded as pathological or dysfunctional. This study takes a different stance and looks at District Health Authorities (DHAs) to see if the NHS can be better understood by accepting Lukes' conception of a "third dimension of power". The study is not focussed around conflicts of interest because the third dimension of power involves situations in which "real" interests may remain unknown. Power may prevent conflicts becoming apparent and interests becoming realised. Because, however, Lukes had suggested that interests may become realised during periods of change, the study focusses on the restructuring which began with reorganisation of the NHS in 1982. The parts played by medical professionals, administrative staff, nursing staff, and lay-members on DHAs are examined and demonstrate the extent to which their activities were influenced by one another and by their external political environment, notably the Conservative government. The mechanisms of power used during the period 1982-1985 when new management structures were established and then replaced by a further reorganisation of management are examined. This shows the extent to which these new management changes became accepted as legitimate and how the legitimation process began with the 1982 reorganisation. Lukes' third dimension of power is confirmed as too restrictive a conception and that power is more subtle than even he had proposed. Nor is it always repressive or manipulative.

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Preface

The initial impetus for the research described here arose at the completion of a project undertaken as part of an Open University undergraduate course. Questions were raised over the pattern of health service provision, over who decided things in the health service, and why. These early concerns with decision-making and decision-makers were soon dropped in favour of an approach which recognised that people who make decisions do so within cultural and structural contexts which are outside their direct influence. Instead, the focus of investigation is on power and identifying the mechanisms of power.

Various conceptions of power are available and these are examined in the first chapter. The literature of social policy, in which the systems functional model of organisations dominates, is examined in both Chapters One and Two. The weaknesses of these approaches are that they do not allow for conflicts which may, in any case, remain hidden from view. Interests (based on some calculation of benefits) are assumed to be the sole reason for action but may remain unrealised. A wider conception of power raises methodological problems and problems for interpretation which are detailed in Chapter One. While these problems cannot be entirely resolved, a strategy was adopted for this research which is described in the third chapter and which necessitated conducting the research in two phases. The first of these used the documentation produced by local health authorities and is described in the fourth chapter. The second phase was a survey by interview and limited to four health districts. This is described in Chapters Five and Six.

Preface

The way power should be conceived within the operation of an organisation concerned with welfare, such as the National Health Service, is re-examined in the final chapter. The extent to which power operates through manipulative processes and through compulsion is acknowledged but the power examined here, which operated during 1982-85 is related more to the colonisation by "scientific" management, a form of knowledge. In future, its values may replace the professional values associated with medical knowledge which once dominated the organisation.

The study would never have been completed without those doctors, nurses, employees, and lay-members of DHAs who gave their co-operation. While their numbers are many, it is only the obligations of confidentiality which prevent me from acknowledging their assistance by name. I must also acknowledge the Open University's Crowther Fund which paid a substantial proportion of my fees.

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Canterbury. I benefitted from this in too many ways to detail here. Suffice it to say that he was always gentle in his criticisms which were always well deserved. The inevitable faults that remain are my responsibility and mine alone.

Chapter One
Power and social policy

Introduction

The functional or system model of political processes has been the starting point for much policy theory and policy analysis (see Ham and Towell, 1985, or Jenkins, 1978). An influential example of this model was suggested by David Easton (1965) which consisted of inputs, conversion processes (the "black box" of decision-making), outputs, and outcomes. According to Ham and Towell, the influence of such models has resulted in much concern in social policy witn describing why policies have had one outcome rather some other. The question addressed has been, in one form or another; "Why have policy outcomes differed from the stated policy objectives of government and its policy making advisors and agents?". The analysis has been concerned with explaining "gaps" perceived between policy intentions and observed outcomes.

This tendency for local outcomes to differ from central government's policy intentions has been observed within the National Health Service (NHS), and the consequences, well documented. Haywood and Alaszewski (1980, p50-54) demonstrated, for example, that despite continued calls for increased funding to enable care to be given for the increasing proportion of the population living beyond 65 years, increased NHS total funds do not appear to have resulted in a corresponding increase in the proportion of funds devoted to the aged.

A further example concerns the intent, established at its inception (Labour Party, 1942), that the NHS redistribute health resources. Research has shown that this redistributive intent appears to have come about, in class terms, to some extent but not

in full. For although, at its inception, medical help became available to all without charge at the point of delivery, a working group on inequalities in health, under the chair of Sir Douglas Black (1980), reported the continued persistance of inequalities in health, and in health service provision between social classes. Geographic inequalities have also persisted, both in the incidence of diseases and mortality (Coates and Rawstron, 1971, and Howe, 1970), and in health service provision at both national (Butler and Knight, 1974) and local levels (Hart, 1971, Knox, 1979, and Phillips, 1979). Butler (1973), for example, showed how little had been achieved in the distribution of GPs nationally.

Explanations for these perceived "gaps" have been offered in the literature of social policy and social administration from various perspectives. However, the dominance of the functional/system paradigm meant that many of these explanations share certain common features. These will be apparent in the literature reviewed in the following chapter and are briefly set out below.

First, in looking for "faults" in a functional system they shared a tendency to pull attention away from the policy-making arena. Attention has been directed at the arena where policies are implemented. Second, this resulted in the focus of investigation being brought upon observed behaviours and observable outcomes. Third, they employed a limited conception of power as decision-making. And finally, perhaps as a consequence, (but equally) perhaps as a determinent, they shared a tendency to ignore the contestable nature of social policy.

Chapter One
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Mishra (1984, pp1-12) argued that much social science, policy analysis and social administration, was restricted to analyses of how policies may be improved within existing social and political relationships. Mishra claimed that these disciplines have, therefore, had a legitimating influence on social policies. However, he qualified this claim because recently, with the resurgence of conservatism (the "new right"), the consensus on s cial policy and social science has broken down. Until this development, social policy analysis had developed within, and had reinf rced, the post-war consensus about the role of the state in the welfare of its citizens.

The contention that the welfare state has reached a crisis of legitimacy is not shared by all. "The real enemy", according to Taylor-Gooby (1985, p20) "of those who seek to advance welfare is not a sudden confrontation, but the continuing development of overall c ntradictions and ambiguities in the welfare state: the old enemy, not the new right." Instead, Taylor-Gooby said "Don't panic! The forces that mould the status quo are still alive" (p142). According to Taylor-Gooby's findings, the welfare state was still safe because it was still highly valued by the population. (The NHS was safest of all because it was the most valued arm of the welfare state.)

These two opposing views of what has been called the "legitimation crisis" differ at heart because their exponents differ about the way that political processes work. On the one hand, there are those who see economic forces at work in conjunction with the state which influence the way the population thinks and votes. On

the other hand, there are those who think that governments have to respond to the wishes, freely expressed and formulated, of the voters. The exponents have different views of what the status quo is and these differences are revealed in published social policy research and analysis. A broad sympathy with the first view will be apparent in reading the account of this investigation that follows.

This is because, despite the reassurances given by Taylor-Gooby and others and the measured support that exists for state provision, since the Conservative government was elected in 1979, there has been a continual process of de-investment of public money in publicly-owned services and industries. In many cases these have been privatised. Moreover, public services have been required to show that the resources they consume represent good value in competition with alternative uses for those resources.

Even the extent to which this disinvestment has been going on has been contentious. The government, which had at first set about reducing state spending and justifying their actions, has more recently begun to claim that no real harm had been done. At the Conservative Party's 1985 conference, Mrs Thatcher claimed "the only cuts made are cuts in waiting lists". The government's statistics, on which these claims were made, have since been challenged in the Radical Statistics Health Group's report "Unsafe in their hands" (1985). A clearer demonstration of the ability of apparently neutral statistical facts to be the subject of differing "political" interpretations would be harder to find. Despite these denials it is apparent that, under Mrs Thatcher's

government, changes in the welfare state have occurred that may justifiably be termed "restructuring" (see, for example, Robinson, 1986).

So then, what has been happening in the disciplines, such as sociology, social administration, and social policy, which were for much of the time that the welfare state has existed dominated by the functional/system paradigm? Without the legitimation function they previously enjoyed, they have suffered something of a crisis themselves, particularly in sociology (Freidson, 1983) but have endured. It is important to be clear that the functional system paradigm, enabled the analysis of public policy to be "approached at different levels and through different disciplinary assumptions." (Jenkins, 1978, p32). Broadly, the approaches offered can be categorised as; (1) those offered by the managerial perspective; (2) those offered by analysis of central local government relationships; and (3) those offered by analysis of entrenched interests. While these approaches overlap and are not clear cut, their key features can be illustrated.

(1) An example of the managerial mode of analysis is provided by Stewart and Sleeman (1967) who examined hospital out-patient departments and concluded that they were not really being managed and also that there was no reason to assume that this was unique to out-patient departments alone. They found no goals or objectives and no periodic reviews. A failure to consult, except through formal channels, was thought to be an explanation for the failure to learn from others' experience or to understand others' problems.

Such studies as Stewart and Sleeman's tended to look at the internal management of the organisation and its functioning, and find faults which have managerial remedies which the organisation itself can implement. Social policies that consist of managerial remedies have often been applied by central government and their consultants to public services as a cure for their ills, and the NHS is no exception to this. One reason for this might be that governments, particularly Conservative governments with their political and ideological links with industry and commerce, have assumed that public service organisations do not have the same incentives to develop better management as do private corporations. The remedies of "better management" have been continuously applied by governments who claim the usefulness of an analogy between the NHS and commercial organisations and have used commercial practice as the first yardstick by which to make comparisons. A more cynical reason for the popularity of the managerial perspective with governments is that such proposals may direct attention away from their policies and actions.

A recent pertinent example of a policy measure based upon this analogy is seen in the recommendations of the NHS Management Inquiry led by Roy Griffiths (DHSS, 1983). This recommended the implementation of the "general management function", common in the management of commercial organisations.

(2) Another approach used by investigators to explain the "gap" between policy intentions and outcomes, has been to search for the location of decision-making and to describe the

relationships between agents or units within the service in an attempt to explain the decisions taken. One question asked in such approaches has been about the extent to which health authorities can be considered as agents of, or partners with, central government. This mode of analysis sometimes goes so far as to ask to what degree local health authorities could be considered as separate political systems. See, for examples, Butts et al (1981), Donnison (1965), Eckstein (1958), Glennister (1975), Griffith (1966), Ham (1981 & 1982), Haywood and Alaszewski (1980), and Maynard and Ludbrook (1980).

A recent development that takes this type of analysis further, is seen in work done on the role of discretion in the implementation of social and welfare policies. See, for examples, Lipsky (1980) and Prottas (1979).

(3) The third approach shares with the second approach a concern for locating the disruptive elements in the system, but takes it furthest by locating dysfunctional elements among entrenched interests. Within health services, these studies have tended to focus upon the relationships between the health service's bureaucracy and officers, on the one hand and its professional providers, on the other. See, for examples, Alford, (1975), Donnison, (1965), Eckstein, (1958), Klein, (1978), Lee and Mills, (1982), and Smith, H.L. (1958.)

The last two approaches are both problematic because any autonomy that local agencies or professional providers might have, has resulted through either their own power or power which was allowed or tolerated by central government.

All three approaches are vulnerable because they seek to distinguish between "decision-making" and "decision-implementing". They ignore the fact that decisions are made within the context of other policies and within a structure of implementation which has been established previously and which may be altered at any time.

However, successive governments have allowed considerable autonomy to medical practitioners (as they have to a lesser extent with local health authorities) with consequent implications for policy making. It is arguable that central governments have not so much allowed as have been forced to allow, or have found it convenient to allow, this autonomy.

The investigation described in the following chapters covered much of the same ground as has been covered by these approaches. For instance, the efforts made by medical practitioners to influence health service policy at a local level were acknowledged. However, an attempt was first made to clarify the context in which social policy is made. This context was not to be limited to particular relationships between parts of a system however it might have incorporated central government and professional interests. It sought instead to reach a theoretical understanding of how power operates within society combined with an understanding of how decisions are reached within organisations, on which the investigation would be based.

This does not necessarily imply the wholesale junking of the idea of the health service as a system in which individual parts serve functions. Such an idea is adhered to by many in the health service as well as by outside commentators and analysts.

Nevertheless, the system model has several recognised weaknesses; an inability to explain conflict resulting in an inability to see the contentiousness of many social issues, an inability to recognise how change occurs, and its concentration upon discrete parts of the system. The attention given by policy analyst's to what they have called "inside the black box" encapsulates this last weakness and has resulted in an avoidance of what is being done in the policy environment to the black box. Any notion of a system in which central government can be seen to have adopted strategies which undermine the system, must be suspect as a basis from which to build an analysis.

Nor does this imply the wholesale acceptance of any of the competing conceptions of power available. Indeed, it was intended that this study might contribute to an understanding of power. Before proceeding to an examination of health policy literature and to describing the investigation, it is necessary to examine the context in which social policy is made. Central to this are the various conceptions available of decision-making and power.

Many policy analysts have thought it useful to distinguish between political models and process models. While, few would claim that this distinction is clear cut, political models are those that look at the people who made a decision and who exercised power, and process models are those that concentrate on the details of how a decision was made. As process models are so strongly linked to the functional or systems paradigm, they are considered first.

Chapter One
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Decision-making as a process

The literature on processes of decision-making has been dominated by a debate between "rationalists" and "incrementalists". The main features of these two positions, and the compromises that have been attempted are set out below.

a) Rationality. The term "rational" has acquired many meanings. What the term means in the literature of decision-making, organisation theory, and management science should not confused with the "rationalism" used to contrast empiricism in science. As Sylvan and Glassner (1985, p3) have pointed out, "theorists who claim that human beings act 'rationally' tend to follow empiricist research programmes".

Within the literature of decision-making, organisation theory, policy studies, and management science, the term "rationality" has been used to model or idealise human behaviour. It was then only a short step from using this model to making predictions. Behaving "rationally" has entailed the setting of commonly agreed objectives, and working towards them. Simon (1957) stated that rational decision-making requires first a decision to make a decision followed by the identification of all possible options, an assessment of all the consequences of all these options, and a choice. Rational administrative "man" existed, like "economic man", for his (or her) usefulness in prescribing how policies ought to be made. "He" does not exist, except in as a normative character in much of the writings of organisation theory (Scott and Mitchell, 1967), operations research (Heclo, 1972), and decision theory (Schlaifer, 1969).

A more realistic notion was that of "bounded rationality" which, as Simon said. "is compatible with the access to information and the computational capacities that are *actually possessed*". Administrative man (the title of one of Simon's books) sought to be rational but failed because of his (or her) limited capacity for rationality.

b) Incrementalism. "Rationalists" were attacked by Lindblom (1959) for their failure to see that decision-makers are not faced with a given problem, or an agreed objective, but have to reconcile conflicting goals. Even when goals are established, there has to be a basis for reconciling value differences, for judging how much of one value is to be sacrificed for another. Instead, Lindblom argued, decision-making is characterised by "partisan mutual adjustment", resulting in policies which were small adjustments to what went on before. This "partisan mutual adjustment" is not totally partisan, because decision-makers aim to avoid conflict and to reach consensus by negotiation and compromise. Lindblom argued that this approach is the only one compatible with the values of liberal democracy. Since even the best analysis can only be a guess about an unknown future, it is better to proceed by experience based learning than on the basis of some doctrinaire plan. Dror (1964) criticised Lindblom's ideas as resulting in no effort to do better. He claimed partisan mutual adjustment is anti-innovative and pro-inertia. Furthermore, it is unjust since "good" decisions are assessed not by their ranking on some objective evaluative criterion but simply by their acceptability in a particular situation.

c) Alternative compromises. Other writers have attempted to resolve the debate between these "rational" and "incremental" schools of thought by drawing on their strongest features. Etzioni's "mixed-scanning" approach (1967), entailed a broad sweep of policy options in which decision makers made a distinction between fundamental and incremental decisions. Dror's "normative-optimum" approach (1964) required rational planning to be offset by some clarification of values, and by a preliminary estimation of pay-offs.

The "process" approaches, outlined here, share common faults. Particularly suspect is the notion of rational choice. Hindess, for example, has pointed out that "the dominant approach in contemporary economic theory elaborates on abstract models of rational choice" and that;

> "the rational choice approach to political behaviour is merely another example to extend a style of analysis that has proved influential in economic theory to other areas of social life."
>
> (Hindess, 1984).

The use economists have made of the term "rationality" has been, like political analysts, different from its everyday sense as something which is intelligent or sensible. Many economists and policy analysts have defined a rational choice as one which was deliberate, internally consistent and one which maximised the decision-maker's objective function. So, rational decision making was defined as purposeful and functional. Certain kinds of objectives have been assumed. So, use of the term "rational

decision-making" has meant that people have been pursuing efficiency goals, say, because policy analysts have valued efficiency as an objective. They have concluded that it would be irrational to pursue other objectives.

Regardless of the value of any particular objective, it would be difficult to conceive of people committed to non-rationality in decision-making and correspondingly difficult to see how these assumptions about people's rationality could explain their behaviour.

Hindess, for one, has shown that the rational choice approach to political behaviour, with its assumptions about the "given ends", the nature of individuals and with its further assumption that political "actors", such as firms, states, etc., are ultimately reducible to individuals;

> "...forecloses serious investigation of major problems concerning the effects of social conditions and political forces on the formation of political interests and concerns, and how they might be changed" (1984, p271).

In addition to the difficulties encountered in applying assumptions about human reason to make predictions about economic and political behaviour, policy analysts have encountered methodological difficulties because they have assumed that the real intentions or objectives of an individual or a group can be judged from those stated. These can differ, not through deliberate or conscious attempts to misrepresent their intentions or objectives but simply because their priorities can shift, as

can their loyalties and commitments to priorities. Policy analysts, in seeking to offer explanations about why people should all pull together, cannot rely upon assumptions about human reason (and consistency in reasoning). Empirically also, these assumptions appear unfounded. For instance, Blau and McKinley (1979) demonstrated how, in professional work settings, people continuously disagree about, and re-define objectives and the priorities they are to be given.

Incrementalism has been offered as an alternative analytical model. One that still relies on partisans pursuing their own objectives, but adjusting them to an outer reality. The incremental model, for the policy analysts who have used it, has a "more realistic rationality", but rationality nevertheless. Furthermore, claims have been made that it is based on what actually happens. This has yet to be shown, for it can also be claimed that people do not necessarily learn from their experiences, and that incrementalism can sometimes turn into what Heclo and Wildavsky call "galloping incrementalism" (1974, pxxv).

It can also be claimed that organisations go through fundamental or radical changes, sometimes in a short space of time. To do so, there has to be some explanation for why the sum of the small incremental, system maintenance, decisions taken resulted in changes that pulled the organisation in a particular direction. Similarly, if there is an objective pulling an organisation in a certain direction, such as those pulling the NHS towards increased care for the elderly, then there has to be an explanation as to why the organisation has failed to respond. Incrementalism alone

failed to provide this kind of explanation, it merely described how objectives were frustrated.

In sum, process models are limited in their ability to offer crucial explanations. It is impossible to learn from them why certain decisions get taken, and not others. They cannot explain why policies are pursued or not, why some decisions are taken and why some others are not, and why those decisions that are taken do not always result in the policies they were intended to. Who defines the problems? who benefits from the decisions taken? and who suffers? They may describe the way in which decisions were taken but not why. So, they may describe the way in which powerful groups in the health service go about exercising their power with consequent effects upon policies and policy making, but they cannot help in explaining the "gap" between policy intent and outcome.

Smith and May (1980) have argued that the debate between rational and incremental models of decision-making was artificial. There was, they argued, confusion between "is" and "ought"; that rational models have been prescriptive, while incremental models were attempting to describe the way things are.

Process models are clearly flawed, they are limited in what they have set out to explain. Yet they have endured and, while the reasons for this are unclear, this endurance serves to illustrate the points made by Mishra and refered to in the opening paragraphs of this chapter. It could be argued that this debate and this confusion has reinforced and enabled social policy analysts in their tendency to take the environmental power balance as given.

For example, Lindblom's claim that incrementalism was the only process that is compatible with liberal democracy is revealing in that liberal democracy is the political system that is prevalent. His claim was calculated to appeal to the bulk of his readers by refering them to a political system (he assumed, probably correctly), that his readers were committed to. Policy analysts that attempt to distinguish between process and political models, and then go on to assume that process models will be useful in offering explanations, are themselves engaged in a political act because of the (legitimating) influence of this kind of thinking. Like Lindblom, their written analyses have reinforced values held within, and perhaps determined by, an existing political system.

So, in general, there can be no clear cut distinction between political and process models; it is possible for powerful groups, whether they be social classes or elites to vary the ways in which they use their power. So, to make a distinction between process and power models is to create an obfuscation which has, itself, political consequences. The obfuscation perpetuated by such distinctions may have diverted attention away from the operation of power within society and its organisations.

Political models of decision-making.

Process theories of decision-making failed to explain the decisions taken because they failed to encompass the concept of power. They avoided the issue of power by assuming that objectives can be identified and agreed, and then that objectives can be pursued by someone or some unit that has the power to

pursue them. More recently, policy analysts have not confined their work to process models. For example, Ham (1982), drawing upon the ideas of Alford (1975), described the professional dominance of consultants over the health service: its executives and its patients. He showed how the incremental processes of decision-making in the NHS were a consequence of this dominance. Hunter (1979 and 1980), too, demonstrated how a "policy triad" came to make decisions that were incremental. Ham and Hunter both recognised that incrementalism was the result of the activities of powerful groups within the health service. While the influence of the systems paradigm is apparent in their analyses, they acknowledged that the capacity for decision-taking is dependent upon power relationships. It is the distribution of powers and authority within organisations that allow the act of deciding.

Political models of decision-making can be differentiated from each other by their different sources of power. These can be, among other things, the state, the government, professionalism, bureaucracy, and the division of labour. These sources of power have different forms of power at their disposal, at different times, and so it can be assumed that they have their power limited in different ways, by other uses and forms of power. Implicit in this statement is the idea that there are social structures within society, all of which entail power relationships. The main theoretical forms in which power has been understood are;

a) Marxist theories of decision-making. These are at the macro end of the political model spectrum. According to marxists, the NHS is intimately bound up with society and reflects the divisions and contradictions of society. The divisions between the class that rules and exploits, and the classes that are ruled and exploited results in a perpetual struggle. This struggle is reflected in the health service. For example, Navarro (1976, ppl89-90), criticised Alford (1975) arguing that medical power results from class power. Other examples of writers who have argued from a marxist standpoint are Doyal and Pennel (1979), Dunleavy (1981), and Ehrenreich and Ehrenreich (1970).

The marxist approach is uniquely credible in offering insights into the workings of health service organisation from a position founded upon an explanation of the wider social and political structure. The other available political models have either totally ignored the wider society of which health service provision forms a part, or have analysed it within the context of an idealised vision of how society should be constituted. This criticism is particularly true of pluralist theories but is also true of the early elitism of both Mosca (1939) and Pareto (1966).

b) Elite theories of decision-making. Elitism does not postulate a class struggle, since the mass are not organised, and since the elite may well be benign. It claims that elites dominate decision-making, by limiting access to decision making and by the absence of a unifying political consensus among the

mass. This model can be seen with Ham (1981 and 1982), Hunter (1979 and 1980), Alford (1975), and Freidson (1970). Taylor's case study (1977), of a dispute over the replacement of a local doctor may be untypical because of the small size of the local community, but showed how the formal structure of decision-making helped the doctors impose their definition of the health needs of the community upon the community and the managers of the health service.

Elite theories may be more obviously attractive to studies of the NHS than marxist theories because of the existence of a powerful, but numerically small group; the doctors. Elite theories do not state that elites get their power from ownership of the means of production. Instead the elite gets its power from the fact that it is organised, while the mass it controls remains a collection of individuals. Why the mass should remain a disorganised collection of individuals is not explained. Although elites can be said to exist, their existence does not explain very much about the ways decisions are made in the NHS. Elite theories fail to explain how the social structure was both established and maintained.

Although Crossman (1972) called the NHS "consultant dominated", Klein (1974, p221) stated that the charges of elitism were not proven because the freedom of manoeuvre of the elite is circumscribed by the overwhelming public agreement that the NHS is a highly desirable institution. However, Klein's assumptions were pluralist and this pluralism is a model of power which is itself questionable, as is shown below.

c) Pluralist theories of decision-making. Power, in this model, is shared between many competing private and public groups. It is a type of social advocacy, with all sides putting their point of view. An example of this use of power was Dahl's (1961) study of New Haven, Connecticut, which Lukes (1974) described as "the classical pluralist study". Not all groups are equal, some are stronger than others, as they derive power from their control of wealth, votes, expertise, etc. Presthus (1964) argued that if pluralism is to work there needs to be a consensus that all have the right to make their will felt and that all will take their opportunity to exercise their power. Pluralism favours existing groups because it perpetuates a bias in favour of existing groups. Playford (1968), for instance, has criticised the assumption that all will accept the natural harmony of interests, and that the status quo should not be changed. Lower group agitation is seen as disruptive. Bachrach and Baratz (1962) argued that pluralists ignore the possibility that power is often used to restrict the scope of decision-making to safe issues. Pluralism is a model in the sense that it is an ideal (specifically it is a liberal ideal), of how society or organisations should function. However, as an explanation it is clearly deficient as so many of factors necessary for its operation are lacking. Power is not equally distributed and consensus is rare. Pluralism's strength is as an ideological model that suits those who already have power over others.

d) Structural theories of decision-making. Structural theories treat power as a variable of the structure of decision-making. (This use should not to be confused with "structuralism", the pre-supposition that there are "deep structures" which underlie "surface" phenomena.) The two main types of structural decision-making theory available are concerned with pressure groups, and with the control of contingencies.

Eckstein's (1960) study of decision-making within the NHS looked at the role of the British Medical Association (BMA) in influencing decisions throughout the NHS. Pressure groups adjusted the form of their activities according to the effective decision-making structure, not necessarily the formal structure. Eckstein explained British pressure group activity by the British acceptance of corporatism, individuals working through groups. Corporatism is the term he used to describe the interplay of governmental structure, activities and social attitudes which determines the form of pressure group politics. Eckstein distinguished between consultation and negotiation. Negotiation took place when the agreement of other parties was crucial to the decision being taken. Government structure, policy, and attitudes were again the factors which determine which, of negotiation and consultation, takes place.

Contingency theories treat power as a large unitary concept, like bureaucracy or alienation. Such studies treat the organisation as systems of independent sub-units with a power distribution with its sources in the division of labour. The power of each sub-unit is related to its ability to cope with

uncertainties. Power is treated as a property of social relationships, not of the actor. Contingency theory is based on Emerson's idea that dependency is the reverse of power (1962). Hickson et al (1971) argued that organisations deal with uncertainty by creating parts to deal with it. The imbalance in the reciprocal interdependances between the sub-units created resulted in power relationships. It was the sub-unit's ability to cope with or create uncertainties that increase the sub-unit's power. This ability varied according to the sub-units centrality to the whole organisation, and the degree to which its role can be substituted by other parts or means. Greenwood et al (1975) modified the strategic contingency theory when used within the setting of a local authority because local authorities do not have to respond to the situational uncertainties faced by other organisations. Political goals took their place and, for some of their services, consumption was compulsory.

Underlying the strategic contingencies theory, is the exchange theory of Blau (1964) in which each party to an exchange has something the other also values and wants. It assumed that the actors have shared interests, but that they diverge on grounds of self-interest.

Strategic contingencies theories have been open to criticism. Clegg (1975), for instance, criticised Hickson's view that power rests on relationships of sub-units towards each other, as being rather like a "game of chess where the pieces gain their power through their current position, rather than gaining their

current position through their power to make moves according to the rules of the game."

Both these structuralist models are derived from the pluralist model, and have the same faults. As explanations they are lacking because power is not equally distributed, and never could be. Consequently, not everyone has something to exchange or to negotiate with. Such things are, themselves, determined as a result of decisions taken by people in powerful positions themselves.

e) Theories of negotiated order. These psycho-social theories concern the negotiations that take place between individuals or small groups, or between individuals and organisations. They are at the micro-end of the political models of decision making spectrum, and although they may indeed occur, they do not take on explanatory power except at an individual, group, or organisational level because they are separated from any notion of a social order. Like structural theories they do not concern themselves with how the micro-social order was established and maintained. The power that medical institutions and professionals have over their patients undeniably exists, and inevitably affect demands for, and allocation of, resources. If patients are considered difficult by the nursing and medical staff as Stockwell (1973) and Stimson (1976) have demonstrated, then the attention they receive may well differ from those who are considered interesting (Becker et al, 1961). Parson's (1979 reprint) work on the sick role exemplifies the power that patients are subjected to by medical professionals,

institutions, and society, while Roth (1962) and Strauss (1963) demonstrated that patients negotiate and bargain to secure concessions from the medical and nursing staff that control their life as patients in an institution.

Clearly, these broad political theories have not relied upon a single conception of power. It may be that different theories and conceptions of power may be more useful in some arenas of the NHS than in others. Klein (1974) argued for a more precise vocabulary that would distinguish between different policy environments and that "decision-making" is but one form of the exercise of power, more appropriate to consensual or pluralist theoretical frameworks. Other forms of power need to be considered in order to understand decisions, implementation, and policy-making. While many different conceptions of power are available, the core distinguishing characteristics of these conceptions are the extent to which it is valid to talk of acts and actors, intentions, outcomes, and structure (for example, see Debnam, 1984).

Power: conflict and consensus, and the domination of values

Decision-making, per se, may be considered as the exercise of a decision maker's power to get someone to do something they would not otherwise do. This decision-making capacity is derived from the definition of power provided by Dahl (1961). As it is conceived around the actual exercise of power, empirical research could go ahead by observing manifest conflicts of interests within organisations. Such a use of the phrase "decision-making" or "decision-maker" does not encompass those situations where the

decision is being made by someone at the weaker end of a power relationship. It is confined to situations where the decision maker has power over another.

This behavioural approach was subsequently categorised by Lukes as the first dimension of power. Lukes has rejected this behavioural approach, focussing on observable conflicts, in which decisions over issues are made. In assuming that conflict is crucial in providing an experimental test of power attributions, pluralists such as Dahl, considered that power could not fail to show up. Such a view ignored the possibilities "that interests might be unarticulated or unobservable", or that "people might actually be mistaken about, or unaware of, their own interests." (Lukes, 1974, p14).

Behavioural research was dependent upon conflicts over goals, preferences, or the distribution of resources between groups. It missed a multitude of covert ways in which power is exercised. The concentration of research on the exercise of power in conflict situations was sure to miss the exercise of power involved in controlling which issues will be allowed to become issues of dispute. It inevitably missed the processes whereby the interests of certain groups and individuals are organised out of the system.

Bachrach and Baratz (1962, 1963, 1970), argued for the need to study non-decision making, the process whereby covert power was exercised through the mobilisation of bias in the organisation. They used Schattschneider's phrase "the mobilisation of bias" (1960) to describe how a set of predominant values, beliefs, rituals, and institutional procedures operate systematically and

consistently to prevent particular individuals and groups raising issues which those who exercise power do not want raised.

Lukes (1974) argued that Bachrach and Baratz did not go far enough. He termed non-decision-making through the mobilisation of bias as "the second dimension of power". Power was most effectively organised when people were not aware that anything was being done to disadvantage them. Lukes' first and second dimensions of power involved parties who were aware of their interests. These interests were "subjective interests". He proposed a "third dimension of power" where a person's real interests were being contravened. These "objective interests" may not have been apparent, but may have been potentially more significant. The situation described is one so subtle that the underprivileged collaborate, even if unwittingly, in their own subordination. The interests of those exercising power and the real interests of those they exclude were in contradiction, but the possibilities for conflict remain latent.

The importance of Lukes' argument was that it showed that those who are at an advantage in an organisation or social system are not necessarily those who could be seen to be wielding the greatest force.

In a similar vein, Clegg (1975) has argued that the emphasis on the overt process of decision-making was inadequate for studying power. Power, he said, was being used in its weakest sense when seen as the resolution of issues, or the outcome of specific changes. In its stronger, more structural sense, power consists of domination and control. Clegg's use of the term domination

differed from those instances where an actor has authority through institutionalised or legitimate power, and achieves obedience, not because of the persuasive content of an instruction, but because of the source of the instruction. Acceptence of this crucial point meant that the management structures used in the NHS became an essential focus for this study of power. Why else would organisations adopt management structures than for the purposes of domination rather than allowing persuasion in a pluralist fashion?

Domination, for Clegg and for this investigation, is articulated through a mode of rationality, which consists in a set of "deep rules" governing the forms that action and thought can take in the organisation. The profit motive, for example, might be the mode of rationality operating in the industrial firm. Accordingly, power is;

> "about the outcome of issues enabled by the rule of a substantive rationality which is temporally and institutionally located. Underlying this rule is the specific form of domination. The progression is from domination-rules-power."

Clegg's point was similar to Lukes', in that the prevailing system of values (structure of domination) works systematically through its expression in the organisation, to the advantage of some rather than others. People within an organisation may not resent their disadvantage because they accept the rules, and therefore the dominant value system, knowingly or otherwise. The implication of Clegg's point was that those who gain in an organisation do not necessarily do so through constantly fighting

battles to get their way.

Despite the support given by Clegg, Lukes' conception of power has been seriously criticised by several writers, such as Wrong, Benton, Hindness, and Walsh et al. Some, like Wrong, sought a fundamentally different conception of power, others have recognised the strength of Lukes' position and sought to replace some of its weaknesses.

Lukes' conception of power was criticised by Wrong (1979) who took the view that Lukes' third dimension of power was idealistic. Wrong devoted a considerable part of his book to describing the forms which power can take. Wrong's broad definition of power, as intended influence, excluded the more general use of the term power which identifies power with potency or mastery. Power is not an attribute of a person or group but the capacity of some persons to produce intended and foreseen effects over others. Wrong stated that definitions of power must be confined to social relationships, (as would Lukes') and must, therefore, take some form. So, Wrong then went on to categorise these forms as force, manipulation, persuasion, and authority. Where Wrong differed from Lukes conceptually, is where he insisted that these forms of power are all intended. The insistance that power must be exercised intentionally is a contention that is difficult to sustain, it being a possibility that A could pursue an objective that would, quite unknowingly, have repercussions that would affect B. Also, actions can be taken that have an intention which is not realised. Power has still been used, even if ineffectually.

Benton, (1981) noted how Lukes' third dimension of power relied upon a distinction between subjective interests and real, but presently obscured, interests. The problem, in accepting Lukes' formulation of a third dimension of power, was that of how to identify the "real" or "objective" interests, for this was bound to rest upon value-dependent speculations about what an individual's or group's real interests were. This would place the social scientist in the position of a "moral arbiter" as he/she would have to determine which of the interests of the actor involved were of value. Lukes made a distinction between interests and power and, as Benton noted, this made it possible for Lukes to maintain a critical distance from the prevailing pattern of "wants", "preferences", and "consequent choices". So, it was possible for Lukes to accord to actors the status of ultimate arbiters as to their own interests, while provisionally withholding the status of immediate arbiters. Lukes conceded that the concept of "real interests" should be protected by two conditions. These were that;

> "real interests must be empirically identifiable and that they must be identified by the objects of the power exercise themselves, under conditions of relative autonomy (in particular autonomy from the source of power exercised over them)."
>
> Benton (1981, p161)

Lukes argument relied upon an empirical test and upon the ultimate recognition by those who have power exercised over them that their interests have been contravened. His argument, therefore, is reliant upon people becoming aware that they have been duped. As

both manipulative processes and the processes of control that Lukes talks about may well continue, the point at which an empirical test should be mounted would be a moving target and might even continue beyond the death of any individual affected. Lukes' position appears, unfortunately, not to be open to the empirical test which he said was necessary. Consequently, his third dimension of power relies upon the judgement of the outsider for determination of "objective interests". However, the position of "moral arbiter" also appears to be difficult to maintain for it requires a judgement to be made of the results for the challengers of challenging and overthrowing the power that they are subject to.

Instead of interests, Benton (1981) proposed the use of "objectives", as these were comparatively self-evident features of everyday life. He theorised power as follows; A can be said to have power over B in so far as when each mobilises their capabilities and resources to the full in pursuit of separate objectives the result is that A's rather than B's objectives are fulfilled. Benton fails to show how the concept of "objectives" avoids the same difficulty as the concept of "interests", a point made by Knights and Willmott (1982), who argued that;

> "The basic flaw in this thesis is its disregard for the fundamental issue of how any social phenomenon, be it an 'objective' or an 'interest' is identified. Benton's argument can only be sustained by taking for granted the value-orientation (Weber, 1948), under which the evidence of 'objectives' within social practices is disclosed - in much the

same way that the one - and - two dimensional views of power stand accused of taking as given the political bias of the system in which 'decisions; [sic] and 'non-decisions' are encountered."

(Knights and Willmott, 1982, p580)

Both Lukes and Benton, then, were correctly criticised for avoiding "the essentially contestable nature of social scientific analysis since observations of social practices, no less than the applications of counterfactual logic, are the product of interpretive procedures grounded in some value standpoint." (Knights and Willmott, 1982, p581). This is a point which, as will be seen, has been elaborated upon by Hindess (1982) and, working in an entirely different tradition, by Foucault (1978).

Hindess (1982) criticised the power as "capacity-outcomes" approach, of which all three of Lukes' dimensions are considered examples, because the securing of outcomes is always problematic, in that the means of action open to actors are dependent on conditions that are not in their hands. Success cannot be guaranteed in any struggle. He claimed that the conditions which govern what kinds of outcomes are possible are not always susceptible to analysis in terms of the extended conceptions of power. Once "capacities" are seen as conditional, they cease to become capacities to secure, to realise, or to control. At best they become capacities to act in pursuit of certain objectives. Power, he said, must be analysed, not in terms of the differential possession of quantities of power, but rather in terms of the differential conditions and means of action available to

contending forces, their strategies and their objectives. To talk of "interests" that are "real" but unrecognised is to suggest that there are, at least in principle, conditions in which they would be truly recognised. There is, he said, no good reason why interests acknowledged in one situation should be considered any more real than those acknowledged in another situation. Hindess's point is that outcomes are secured under conditions of struggle, and they are not a reflection of the initial conditions of action. He said;

> "We must deal with the practices and struggles of definite agents and forces employing particular means of action and strategies in the context of particular conditions of struggle, not all of which are in the hands of the agent in question."

The points Hindess made are significant because they make the task of defining a third dimension of power, as either Lukes' has proposed it, or as Benton has tried to re-define it, an insurmountable problem. This is because the "real" interests need to become recognised as real at some point in time, and this may not be possible. Either they may be concealed, through processes of manipulation or of an ideology, long enough for the persons affected never to realise it, or else the affected persons' interests may be harmed, once they have been realised, in that struggle. Consequently, the study of power can not always be open to empirical tests.

So, Lukes' third dimension of power cannot be accepted as the last word as it ultimately places reliance upon empirical evidence when empirical work may not be feasible. Benton's reformulation fails to get round this difficulty. Power would appear to operate even more widely than Lukes has proposed, and it may be possible to posit further dimensions of power (fourth or fifth dimensions) that operate more insidiously.

A different approach to power was apparent in a further criticism of Lukes' argument. Walsh et al (1981) argued that the domination of values is conceptually different from the exercise of power. They argued that "the exercise of power characterizes [sic] only part of organizational [sic] operation", and that in order to see how the whole pattern of operation of an organisation benefits some rather than others, the embracing concepts should be control and domination rather than power (pp 148-49). The overt exercise of power, they termed control. This overt exercise of power, or control, is necessary only where there are conflicts that arise from divergencies of material interests (conflicts of interests), or where there are problems maintaining consensus. The advantaged seek to avoid conflict or the overt exercise of power by the maintenance of consensus. Walsh et al (p140) drew a distinction between "being motivated and not being motivated to pursue interests". They also distinguished between commitments to values, the first of which is consensus and is defined as a shared commitment to the organisation's values. This consensus on values may be either genuine or manipulated. Second, there may be what Walsh et al termed "unthought consensus". Third, there may be "dissensus" on values, and therefore, conflict on the valued ends

of the organisation.

Walsh et al admitted to the theoretical possibility that consensus may be genuine, but only as a rarity to be found in religious orders or certain voluntary organisations. They considered that where there is consensus it is more likely to have become possible as either manipulated or unthought consensus. Their use of the term "dissensus" was not to describe the situation when groups within the organisation commit themselves to an alternative set of values than that which dominates. The term described a situation where there is disagreement over basic values or organisational objectives. They cited the attempts made by Trades Unions to have paybeds taken out of NHS hospitals. Parkin (1971) argued that total dissent is unlikely, it being difficult to maintain a value system that is opposed to the dominant value system. Walsh et al defined unthought consensus neither as an acceptance of values and operative rules, nor as a rejection. It is that no coherent alternative to the dominant value system is formulated. Motivation might well be erratic or intermittant, but most importantly radical change would not be pursued as this would require the articulation of an alternative set of values and a commitment to them. Consequently, where there is consensus, it has probably been arrived at through manipulative processes such as, for example, organisational socialisation as described by Salaman (1979), or through group pressures as described by Janis (1982).

Power may operate, in this sense, in ways that may, while having purposes for the operator, may independently affect others in ways that neither those with power or those affected by its operation may know of. A structure of values and beliefs, or an organisational ideology, may serve purposes for the advantaged in a social system but may have other and unknown effects upon others. Studying the structure of organisational advantage is not simply a matter of seeing who wins in particular conflicts, for the concepts of interests and of values, as well as those of power and authority must be taken into account.

In sum then, these points mean that the empirical investigation of power will be problematic because manipulative processes will not always be apparent. Such processes may well remain hidden, and may need to remain hidden, if the they are to work. And, of course, covert manipulative processes may well remain hidden for considerable lengths of time. Nevertheless, the problems will be less where manipulation does not have to remain covert. This may occur when policies or changes in policy are introduced by the dominant or advantaged persons or groups and not by the challenging or the disadvantaged. While recognising that positions of advantage or disadvantage are dependant on circumstances, the processes of manipulation may make it possible to study power in senses wider than "decision-making". The processes of manipulation would then constitute the "practices and struggles of definite agents and forces" that is required of a study of power (Hindess, 1982). Under such overt circumstances, that is where some group or individual is able to gain advantage, it is also possible that policy-change may carry with it a

commitment to new values, either explicitly or implicitly.

In discussing the problems and difficulties of identifying the mechanisms or processes of an alleged exercise of power, Lukes (1974, p47), quoted from Gramsci's Prison notebooks (1971), and suggested that;

> "it can be highly instructive (though not conclusive) to observe how people behave in 'abnormal times' when 'submission and intellectual subordination' are absent or diminished, when the apparatus of power is removed or relaxed."

Lukes also noted (on p23) that to focus on actual and observable conflict is to assume that power is only exercised in situations of such conflict;

> "One does not have to go to the lengths of talking about 'Brave New Wor·d', or the world of B.F. Skinner, to see this: thought control takes many less total and more mundane forms, through the control of information, through the mass media and through the processes of socialisation."

Lukes was describing a situation in which thoughts are controlled, although his argument does not go so far as to describe how the situation comes about. One way forward here, might be to look at the way language relates to thought, power, and intentions. The empirical study of power required a new approach, one that would not ignore the effects of language upon power and one that would not ignore the fact that the evidence of power would be comprised of language. The difficulty is that, in acknowledging links

between power and language, further methodological problems have to be recognised. These are elaborated towards the end of this chapter.

Language is important to an investigation of power because, if Lukes' third dimension is, at least, included, then it involves situations in which thoughts are controlled. Thought, if not exclusively dependent on language, is inconceivable without the symbolic order in general. Benveniste (1971) made the point;

> "Thought is nothing other than the power to construct representations of things and to operate on these representations. It is in essence symbolic."

While some sociologists have recognised the place of language in cultural formation (Centre for Contemporary Cultural Studies, 1980), little work appears to been undertaken that applies it to the formation and reformulation of organisational cultures. Despite some recent exceptions (Atkinson, 1984), it has largely been ignored within policy analysis and social policy. Weedon, Tolson and Mort (1980, p215) concluded;

> "..., work examining the operation of various institutional sites - particularly the apparatuses [sic] of the state - has as yet paid little attention to the structures of language and modes of signification which play a crucial role in the construction of official discourses."

One early and notable exception to this general avoidance of the place of language in policy analyis is that of Murray Edelman (1971). Indeed Edelman includes all symbolic, not just language, acts in his explanation of "mass arousal and quiescence" (his book's subtitle). He shows how politicians obtain arousal and quiescence by making metaphorical (pp65-83) reference to things which are valued or feared, such as patriotism or others (enemies). Professional politicians are accused, in this book, of using a population's deepest psychological needs (pp53-64). Thus they create and recreate myths and rituals which mislead and distort reality in order to gain support for their actions. Edelman is undoubtedly correct in describing politics as a process of "changing the demands and expectations" of people (p7), but the emphasis his explanation places on people's psychology might be questioned. There might be more to people's thoughts than the attitudes and prejudices which result from their psychological needs. The book's major concern is with politics as being misleading and involving misrepresentation. This is its major limitation because, while this undoubtedly does occur, people are capable of casting aside their prejudices and predisposing attitudes, and of being convinced by reasons. While deception and misrepresentation occurs, the importance of language (and symbolism) in politics must also include its structuring of reality and truth for those involved. Events have meaning for those involved because of the way they think, in language, about their social (and organisational) surroundings. For these reasons, Edelman's book - for this and any other study of power, is limited but these ideas are undeniably important.

Chapter One
Power and social policy

Perhaps the reason why relationships between power, language, intentions, and thought have been so largely ignored, is the strength of empirical traditions in much social policy analysis and social administration. Most social sciences encounter difficulties when attempting to come to grips with intentions in social settings. The social sciences have found it easy enough to measure and observe people's behaviours while conveniently ignoring the fact that much social behaviour is meaningless without some understanding of what that behaviour means to the people whose behaviour is being observed. Sayer has used the example of voting behaviour to make the point that intentionality has not proved amenable to empirical investigation and consequently behavioural approaches have been privileged (Sayer, 1984, pp33-35).

The consequence, for much of social policy analysis, of ignoring the relationships that might exist between language and power has been that much of it has overlooked language/power when undertaking empirical investigation. It has tended to search for data which it can accept at face value. The criticisms, outlined earlier, that Lukes made (1974) of the empiricists' concern with the processes of decision-making, illustrate this point. The term "decision-making" is predicated upon there being a "decision-taker". The very term, itself, makes "decision-making" an area of study limited by its non-inclusion of power.

Social science has looked at spoken and written evidence with justifiable suspicion and ignored much of the theoretical work that has developed into language and power. Much of this work has

French origins but has been thoroughly translated during the past ten years. Language theorists and social scientists have conducted their work in very different terms. For instance, where social science speaks of intentions, the other speaks of desires. The use of different terms has affected their analyses but, however, they both share an interest in power in social relationships. While social sciences have approached power in its restricted decision-making sense, wider approaches have proved fruitful.

While space does not permit a full consideration of language theory here, the main developments need to be outlined in order to draw out the implications they have for a study of power.

The early work of Saussere (1915, translated 1959) broke with usual or "common sense" notion in which language functions as a nomenclature: as an instrument of communication and independently of the meanings being expressed. According to this view, language is neutral and it follows that it is natural to suppose that what is read or heard reflects what it is that the writer or utterer has experienced. This view of language was apparent in much of the techniques of social science. If instead, as Saussure proposed, language was to be seen as an arbitrary and conventional system of signs, then it "signifies reality by bestowing a particular, linguistically structured form of conceptual organisation [sic] upon it" (Bennett, 1979, pp4-5).

Feminists, who clearly exemplify the articulation of interests that remained latent and unexpressed, have argued against the position of, notably, Lacan (1977). Lacan (1977) had proposed a theory of language acquisition based upon the structuring of psyche, language, and subjectivity in which the placing of the individual speaker within language was gender-specific: the psychological stage at which language is acquired by individuals ensured the power of men. In "Man made language", Spender (1980) for instance, has argued a much stronger role for language in the formation of power relationship between genders. For instance, the use of "men" to mean "people" has resulted in women being represented in discourse as a secondary sex (see pp147-151).

Saussure's view has been much criticised because of the contradiction between the arbitrariness and the presupposition of a speech community which already knows and recognises the meanings it will hear (Derrida, 1973).

It is the work of Foucault which has been most significantly concerned with the relationship between language and power. He rejected the approaches made by Sussure, Derrida, and Lacan for the general nature of their theoretical work and insisted on "the historical specificity of the particular language act and the historical determinations which may influence its appearance" (Weedon, et al, 1980, p209). For Foucault, concepts are formulated within any given historical instance. In an oft-quoted passage in his "History of sexuality" (1978, p88-89), Foucault described the way power is commonly perceived;

> "... the representation of power has remained under the spell of monarchy. In political thought and analysis, we still have not cut off the head of the king. Hence the importance that the theory of power gives to the problem of right and violence, law and legality, freedom and will, and especially the state and sovereignty.... To conceive of power on the basis of these problems is to conceive of it in terms of a historical form that is characteristic of our societies: the juridical monarchy. Characteristic yet transitory."

According to Foucault, this characteristic form has gradually been replaced by "...quite new mechanisms of power that are probably irreducible to the representation of law." Instead Foucault (1978, pp 94-95) proposed that power comes from below. He said;

> "There is no all-encompassing opposition between rulers and ruled..., no such duality.... One must suppose rather that the manifold relationships of force that take shape and come into play ..., are the basis for wide-ranging effects of cleavage that run through the social body as a whole.... Major dominations, are the hegemonic effects that are sustained by all these confrontations."

Significantly Foucault stated that "Power relations are both intentional and nonsubjective... they are imbued, through and through, with calculation: there is no power that is exercised without a series of aims and objectives". This led Foucault to state;

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"...perhaps we need to... decipher power mechanisms on the basis of a strategy that is immanent in force relationships."

Foucault's conception of power as knowledge stands in marked contrast to that conceived of in much policy analysis, and political science. (Although, there are significant common points. Foucault, for instance, shared with Wrong, the idea that power is intentional.) To adopt Foucault's position, power and force relations would not be limiting power to one, two, or three dimensions.

Accordingly, power relations in the investigation which follows are not confined to formal organisational structures. While these are important, power relationships also comprise the working practices and everyday confrontations that take place. The mechanisms are many and various and may include policy statements, minutes of meetings, attendence at meetings, contracts of employment, the drafting and re-writing of memorandums, disciplinary procedures, and codes of practice regarding things said in confidence.

In the next chapter, policy developments and power within the NHS will be considered together with the literature, both professional and academic, which has accompanied and participated in these developments. Before that, however, the methodological problems in researching power and which became apparent in considering the conceptions of power available, need to be outlined. The strategies for coping with these problems will also be considered, although the design of the investigation itself will wait until the third chapter.

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Methodological problems

The relationships between power, intention, thought, and language were discussed earlier where methodological problems were also anticipated. However, earlier the discussion was confined to how power, intention, and thought were related to language (ie; the theoretical considerations related to how far thought is framed by language and the implications of this for determining intentions and articulating interests).

Methodological problems arise because any empirical evidence, whether written or spoken, would itself be constituted in language. While language alone cannot be the revealer of power, because there may be little compulsion on those with power to say anything (leading to problems for the "selection" of evidence), language is the medium by which those with power, or those affected by the operation of power, formulate their thoughts. In the formation of thought, and in convincing others, some social scientists (for example, "realists") would assume that "power-holders" were sure of the reasoning behind the decisions they found themselves making. This is an assumption that may not be warranted (and, perhaps should be avoided) but, for the purposes here, it may be assumed that "power-holders" would, at least, be prepared to defend their reasoning (if required).

It is important to note that the opinions expressed could be accorded varying status. It is not necessary (and ultimately not possible) to interpret opinions at face value alone. As will be seen, in examining the literature in the second chapter, the opinions expressed were taken to represent the authentic voice of

those professionally involved in the NHS. It was necessary to outline what was being said before going on to look at these expressions in any other way. Whether these stated opinions reflected ideologies or whether they were, in themselves, an attempt to influence policy outcomes was intended to be an integral part of the analysis described in later chapters.

The same can be said about any empirical evidence that would be gathered. What is read or said could be regarded as consisting of expressions of opinion made by people who were aware of their possible audiences. To some extent, then, these might not have been authentic expressions of opinion, but expressions of people attempting to achieve something by their expression (professional prestige or an influence on outcome, for instance). While this has implications for the "selection" of evidence, it also has implications for the operation of power within the organisation. Public posturing is purposeful, it is intended to gain some effect.

The observable data, whether written or spoken, could have been interpreted in yet another way than that presented at face value: if not as expressions of opinion designed to serve political purposes, then as ideology. As ideology expressed through discourse and published in professional journals, conference papers, management manuals, etc., these opinions could not simply be interpreted as "views" held by people, but as "views" constituted of thoughts framed and contained within the language they had used. The language used, together with the visibility of the expression in various processes with their accepted meanings,

played some part in the formulation of an ideology, or in ideologies, that were then given expression.

It is clear that any planned investigation must inevitably have relied upon data which would be ideological. Ideology, by common definition (Sumner, 1979, part one) implies some degree of falsity and this has to be accepted if the notion of objective or "real" interests (necessary for the existence of Lukes's third dimension of power) are also accepted. While earlier, it was argued that Lukes's third dimension of power could not be accepted as the last word, what was expressed through language (or action) has counterparts in the non-expression (or lack of action) of un-thought out interests. The problem for research might be expressed in the form of a question: how would it be possible to tell whether interests were un-thought merely because they were not articulated (or acted upon)? Again, how would it be possible to tell whether thoughts, or lack of thought, were formed by, determined by, or constrained by, an ideology or ideologies? And also, how would it be possible to tell whether justifications for actions were genuine reasons or rationalisations (perhaps made by reference to a legitimating ideology)?

Any empirical investigation feasible in this, or any other social investigation, would have to include an examination of the interplay of the commitments of the various "actors" as expressed by those involved. These expressions would have had to rely upon written or spoken communications some of which would constitute what Searle (1969) terms "speech acts"; their essential features are tied directly to the intentions they serve (not persuasive

intentions but where the intention is part of the meaning, for example, acts such as promises, signatures, and importantly, decisions recorded in minutes of meetings). In his 1984 Reith Lectures, Searle (1984, p78) made the point that;

> "For a large number of social and psychological phenomena the concept that names the phenomena is itself a constituent of the phenomenon... So, for example, in order for people to get married or buy property you and other people have to think that that is what you are doing. Now this feature is crucial to social phenomena. But there is nothing like it in the biological or physical sciences....But many of the terms that describe social phenomena have to enter into their constitution. And this has the further result that such terms have a peculiar kind of self-referentiality...'Promise' refers to whatever people intend as and regard as promises."

The same sort of process, the settling of cultural definitions, can be assumed to go on within organisations, such as the NHS, as goes on within wider society. Thus, whereas earlier it was noted, that social science concepts, such as "power", "rationality", or the "role" of management, are themselves socially defined, and consequently contestable. The formation of conceptual approaches within the organisation of health care will be demonstrated in the next chapter. Such concepts, for instance, of "delegation", "accountability", "levels of work", and "professional advice", were all being determined and refined within the NHS for use during the period. These were uses that were negotiated, hence the meanings given to these concepts was contestable within the

organisation.

The meanings of concepts to those working within the NHS, despite their contestable nature, was thought essential to an adequate interpretation. For example, the view that consultants, in the acute sector particularly, have dominated provision in the NHS has been held by administrators, nurses, GPs, external commentators, and perhaps by some consultants. Whether this view was "true" or "false" (by whatever criteria might be adopted for its validity), or whether it was justified (again, by whatever criteria), it was a view that has been expressed for some considerable number of years. It was the view itself, the extent to which it was widely believed, that might have consequences for changes (or, indeed, any lack of changes) in health service policy and organisation.

To conclude this section, the subject of the study, power, affected the intentions and objectives of the investigation. Empirical evidence would be, to use Bhaskar's phrase, "concept dependent" (1975). It was essential to evaluate and criticise the political actors' and the organisations' own self-understanding. Unlike the "natural" sciences, social science cannot stand apart from common understandings of social phenomena but has to incorporate them. Part of the intention of the study was to arrive at an understanding of what meaning was being given to the concepts and terms in use in the NHS at the time by the people using them. An understanding of power in the NHS requires an understanding of the organisational culture, and consequently the meanings that concepts in use have. Sayer (1984) wrote;

> "Systems of meaning are negotiated by people in the course of social interaction. As such these systems have a conventional character - they become conventions according to which actions of individuals can be related..."

It was also essential to outline where the meanings given to concepts were not uniformly agreed upon because it was assumed that conceptual structures, when reinforcing power structures, can be misunderstood. It may even be their very ambiguity or deceptiveness that lead to them being adopted.

Finally, one of the aims would have to be to recover the intention behind statements. This would be problematic because any social science or social knowledge depends upon an understanding of language, or a set of conventions, which can be used with a variety of intentions. It could not be assumed that any empirical evidence would be pure. Few of the truths that might be revealed by empirical research would be able to be reduced to statements of fact. In other words, this resulted in a rejection of the idea that what was empirically observable would constitute reality. Instead, the empirical observations had to be regarded merely as manifestations of reality.

The requirement to interpret the evidence

Because any assumptions regarding the value of "raw data" have had to be rejected, the methods and techniques used in empirical "sciences" have also had to be rejected. Empiricism validates its claims to truth by reference to experience or observed knowledge.

Its methods and techniques aim to reduce errors that would affect these claims. The rejection of any attempts to mirror empirical or positivist "natural" sciences had a deciding influence on the methods used in this investigation and described later in this chapter. It resulted in the necessity to establish some criteria, other than observed experience, by which what was to be said, as a result of the study, could be claimed as knowledge.

The extent to which the social sciences can follow the model of the natural sciences has been the subject of lengthy debate and has been the starting point for a considerable body of literature. For example, Keat and Urry (1982, p1) refered to the methodological unity of the natural and social sciences as "the central debate" within the philosophy of the social sciences.

Intertwined with this debate has been another which has been concerned with the relationship of empirical evidence to theory: is science to be a rational or empirical exercise? Sylvan and Glassner (1985 p3) distinguished these by reference to Galileo and Bacon. Rationalists, like Galileo, defined science as consisting of;

> "... reasoning about nature's hypothesized mathematical structure; towards this end, observations and experiments were of use. For Bacon (the empiricist), the task was to accomplish more and better observations, and to generalize [sic] these observations."

Thus, for the rationalist, empiricism involves making observations which yield empirical knowledge, which is to be distinguished from scientific knowledge. Sylvan and Glassner (1985, p1) claimed that "it is becoming evident that empiricist research has done little to increase understanding of the social world." Writing of what he calls "the lost legitimacy" of the welfare state, Mishra (1984, pp 12-16) claimed that the promise of a social science was "more a promise than an accomplished fact". They both infer that social science, (by which is meant empirical social science) has failed to offer solutions to government or society. (This is a criticism made of social sciences but, in contrast, not made of the natural sciences where it is assumed that "the application of scientific knowledge yields direct material benefit" (Yearley, 1984, p4).

There was no shortage of precedents to encourage the view that science requires the interpretation of observed data and the rejection of empiricism (and positivism). The problem was that any number of interpretations might have proved possible. For example, in the forward to his book "The evolution of the British welfare state", Fraser (1984) outlined seven perspectives that have been used in the research and writing on welfare history. These were; whig, pragmatic, bureaucratic, ideological, conspiratorial, capitalistic, and democratic. These make it possible, he concluded, for the same policy to be interpreted simultaneously as;

"a benevolent reform;

a solution to practical problems;

an effective bureaucratic expedient;

in conformity with prevailing ideas;

a prop to the existing social and political system;

an asset to industry; and

yet also a legitimate popular demand."

In a history, as this investigation is in part, it may be possible to detect strands of interpretation written from any of these seven perspectives. For, while the strength of pragmatic and bureaucratic impulses towards change must be recognised, so too must the role of ideas (ideology) in formulating the events. So, it would be naive to do so without taking account of the social basis for those ideas, rather than assume any intrinsic rationality. Broadly, any historical account encounters interpretation problems at two different levels. On one level, there are likely to be as many versions of what had happened, who had used power, and with what intentions, as accounts available. One person's version of the truth is as good as anyone else's. And also, at another level, the researcher could not assume any privileged position.

In accepting that any statements about power (in the NHS) must take into account the beliefs and cultural meanings that people adhere to or dispute, and in rejecting the empiricist/positivist notion of science, it could be argued that what was real for people within the NHS constituted the only reality which could be known. Reality would then be a matter of the subjectivity of the actors involved. The study could then have been concerned with how those people constructed their reality and how their realities had consequences for the policies, decisions, and organisational

behaviour under investigation. If this argument were accepted, truth has to remain relative, a matter of the collective subjective opinions, and could only be validated by reference to either the actors' subjective experiences or the conventions of other social scientists. Such an approach, while relying on experience for validation, would involve a rejection of empiricism because it would claim that more can be known than the actual behaviour of human actors.

As will be seen in the following chapters, this investigation proceeded by gathering data and making observations of the social world of people in the NHS. How these observations were obtained is described in Chapter Three. While making these observations, particular attention was given to the use of such concepts as "community care", "delegation", "participation", or "client-care". The investigation has attempted to see how such terms as these were derived, defined and used. On their own, such terms have little or no meaning. The reason for attending to them was that their meaning was negotiated, changed in use, and defined in relation to other terms in currency. Moreover, the investigation attempted to see how these terms were used by whom.

The relativism of this approach has to be acknowledged. According to "objective" notions of science, such relativism is unacceptable. The problem, for example, in investigating power, as it was conceived earlier, was that it recognised "real" interests, or "objective", interests that might be unknown to the people on whom power was operating. The advocates of "realist" science, such as Bhaskar (1975), Giddens (1976), Keat and Urry

(1982), and Sayer (1984), would all accept the criticisms made of empiricism from the subjectivist or conventionalist notion of science (Lovell, 1980, p17) but would argue against any relativism claiming that reality exists independently of our conception of reality. Realists argue that there is knowledge over and above that which can be known by the people involved. Thus, the theoretical statements examined, in which there were "real" or "objective" interests that might remain hidden from the people whose interests they were, were "realist" statements.

Investigation within a realist position would encompass the established requirement that, if it were arrive at a version of true events, then these events would have held some truth for the people involved. Therefore, these truths would have framed some of their opinions and intentions and perhaps then to have guided some of their actions. However, over and above this, a realist inquiry would seek to avoid relativism by claiming that there are truths beyond those which the actors might have access to.

The most frustrating feature of realism is that its advocates make no satisfactory attempt to show how their independent reality can be known (or even how it can be conceived). The frustration was explained by Gowans (1982) in reviewing Trigg's formulation of realism;

> "...: either (1) we have access to reality via some factor, say experience, in which case we are in danger of mistakenly reducing reality to experience, or (2) we do not have access to reality at all, in which case reality becomes a Kantian thing-in-itself."

The "new social realists", such as Keat and Urry, have attempted to bridge this dilemma by claiming that various interpretations must be made in combination with each other. In describing interpretation within their "theoretical realism" they wrote;

> "..., we need interpretive understanding to identify the intentions of individual agents, and the contents of the systems of belief and value that are present in a given society. But this must be combined with an analysis of how an agent's acceptance of such beliefs and values is causally operative in his or her actions; and of how systems of belief are causally related to the structural relations and mechanisms present in specific social formations." (p227)

Realists are inevitably falling between two stools. Either they are forced to rely upon objectively known material conditions and situations to validate their claims, or they are forced into idealism. As the source of validation of the truth of their statements, these are incommensurate: neither admits the validity of the other. In their rejection of both these positions as the guarantee of the truthfulness of their statements, it cannot be claimed that their use in combination is sufficient. Realists take a position which admits the relativism of which they have faulted subjectivism and which admits the materialism of the experienced world of which they have faulted empiricism, or else they admit nothing. They cannot have it both ways.

Chapter One
Power and social policy

Hindess (1977) has faulted realism on the grounds that it is a science in which reason is in a privileged position above emp'rical evidence. This is an assumption which, itself, can be judged unreasonable. Hindess's book was an attempt to demonstrate the "pernicious effects" of philosophical and methodological interventions in the social sciences. In this Hindess has demonstrated that "there can be no rational or coherent prescriptive method" (Hindess, 1977, flyleaf). While this kind of criticism is commonly made of the social sciences, it is reassuring (or equally alarming) to note that similar statements have been made about the natural sciences. For example, Feyerabend (1978), who held that Galileo's successes owed more to his rhetoric than his methods, wrote (p179) that;

> "...science is much more 'sloppy' and 'irrational' than its methodological image...., they are liable to hinder it [science], because the attempt to make science more 'rational' and more precise is bound to wipe it out, as we have seen."

The arguments advanced by Feyerabend do not constitute a rejection of rigorous method in science. Only that the method of the sciences must include a recognition of the value within science of dropping cherished theories, for which there may be substantial supporting empirical evidence, in favour of different theories for which no empirical evidence, and perhaps no suitable data gathering techniques, are yet available, provided only that those theories might enable further work, or further knowledge to be acquired.

Under such conditions it was possible to justify the approach adopted in this investigation. Between one extreme where it is claimed that all truths are relative and that there are no absolute truths and the other extreme where it is claimed that no truths are relative and all truths are absolute are less dogmatic positions. These recognise that there are some things about which things can be said with absolute certainty, and that there are other things about which things can be said with less than absolute certainty. No-one would seriously dispute, for instance, that District Health Authorities exist. On the other hand, no absolute truths can be stated about power because it is impossible to reduce power to a material or objective reality. The best that can be hoped for is to be able to make statements that are consistent in themselves and in relation to the things about which absolute truths can be stated. There are degrees of truth which make it possible to derive conditional statements about power in the NHS.

To sum up, the approach used in this investigation has been one of scepticism applied to both the relative truth of the subjective evidence available and to the possibility of making claims about the real interests at stake in the power relationships affecting people involved. No claim could be made that this version represented any absolute truth, only that it was as near to the truth as logically possible. Two examples from the following chapters illustrate what is meant by this.

The first example concerns the opinion, frequently expressed by medical staff, that administrative and management structures do not really matter and that what makes the organisation work is the quality of people and the relationships between them. They were ready to attribute management problems to the personalities involved. This composite view can be accepted as what was conventionally believed to be true. As such, it is something which may influence the behaviour and other opinions of those that expressed them as what they believed to be true. They must, therefore, be recorded. However, they must also be treated with some scepticism, particularly if evidence was available which suggested either that the explanation was inconsistent or that other things were believed which yielded the explanation bankrupt. With the example cited above, this would mean that credence is accorded to the notion that structures are important, despite what people have said, because they have also said that one structure was better than another. In such an example, the criterion used to judge whether the statements that result from this investigation represent the truth, was that of logical consistency. The statements that comprised the evidence were subjected to a question of whether or not they make for a consistent explanation.

What is meant by "logically consistent" is less easy to illustrate when a concept such as "interests" is considered, because the concept is so crucial to the concept of power. The methodological problem that was recognised in that earlier discussion arises because of the difficulty in saying how these interests can be known. Can it be assumed that what are conventionally, or

subjectively, expressed as medical or as nursing interests, are really the interests that should be acknowledged in this study of power? The discussion above would suggest not. To take the second example, when interviewed, nursing staff frequently expressed the view that the introduction of general management would be against nursing interests, it would deny the nursing role in management. If this conventional view of nursing interests were accepted, then it would be possible to demonstrate some way in which they had gained through possession of the management role, or some way in which they had lost out after they had lost it. To be consistent with the previous example, however, some alternative conception of what the nurses' "real interests" are would have to be available, and the the approach adopted in this study is that there is no hidden reality to be known.

No solution to the dilemma illustrated by these two examples is available, so the claims made as a result of this investigation can only represent the truth as far as it is possible to know it. This means that certain assumptions have to be made which may be challenged. Nevertheless, every effort was made to ensure that these assumptions were reasonable. So, while recognising that there is no reason to accept that interests are consistent over all time the study went ahead on the reasonable assumption that there was some consistency of interests over the period under investigation, at least on the part of those whose power (it could be assumed also) was in least doubt. These interests were those of the Government (and the political forces it represented) which implemented the reorganisation and the transformation of management culture.

Without claiming any knowledge of what people's real interests were, it was reasonable to assume that people's real interests were not being served when dominated to such an extent that they were unable to acquire the ability to know their own interests. And, of course, it recognised that these interests were not to be confused with the apparent intentions of the political actors under specific observation. The actions, and apparent motives, were to be regarded as manifestations of power which would, itself, escape direct observation.

Chapter Two
The National Health Service and power

Introduction

Chapter One was concerned with the problems likely to be encountered in researching power. These were both conceptual and methodological because the nature of power both depends upon and determines how it is to be identified and researched. The concept of power as merely the ability to influence decisions is inadequate. Instead, it was argued that power operates in many and various ways and should be conceived as the ability of people to think, to articulate, to accept, and to respond to other peoples actions (including their speech actions). Only some of these might reveal themselves through empirical manifestations and these ought not to be confused with power itself. These manifestations were themselves affected by the operation of power. It was also argued that some of the methodological problems could be overcome by studying power within a period of organisational change.

In this chapter, the restructuring of the NHS in 1982 will be examined - through the academic and professional literature. This organisational change was selected as a suitable and opportune means to investigate power. However, in reviewing this literature there are several points which should be seen as salient. First, alterations in power relationships do not necessarily result in overt conflict. Such alterations would, more likely, result in changes to the organisational consensus concerning who can act in certain situations. The research should identify both the processes by which roles were re-shaped, and the scope for actors to pursue their "recognised interests". Second, the ideas of

organisational consensus and of dominance, assume acceptence of the proposition that, while much is contentious, certain arenas are recognised throughout the organisation as the principle domains of certain parts of the organisation or of certain actors. Third, the thoughts of people published in professional journals and as a result of seminars and conferences were attempts to both reflect and to influence professional opinion. They have to be read as such.

No hard and fast boundary is drawn, in this chapter, between academic and professional literatures. Both, in their separate ways, have attempted to influence developments in policy. As will be seen, the literature suggests that the organisation of health care has been dominated by medical professions, although some writers have detected or predicted a relative decline in medical power. Nonetheless, this chapter will demonstrate the concerns which have been expressed about the limited influence of administrators, patients and other interested parties. The expressions of these concerns in the academic and professional literature played some part in the reorganisation. It must be presumed that the concerns expressed were also passed on to the literature's audience.

As the reorganisation was implemented, the professional literature was perhaps more influential and was certainly more prolific. For the period immediately around the 1982 reorganisation, the focus of this review will shift more onto the professional literature because it demonstrates the formulation of opinions and concepts concerning people affected by the reorganisation. The

professional literature also demonstrates the endurance of the empirical tradition and the durability of the empirical misconceptions of power described in the first chapter. Issues of power within the organisation were translated, for the medical professionals, into issues of their representation in decision-making. For the administrators, power was translated into a concern for seeing that operational and strategic decision-taking took place at appropriate levels.

The 1982 NHS reorganisation involved the replacement of ninety Area Health Authorities (AHAs) with one hundred and ninety two District Health Authorities (DHAs) in England and nine DHAs in Wales. Events since the reorganisation means that it may now appear irrelevant. However, at the very least, it provided an opportunity for an examination of the processes at work by which legitimate dominance or the arenas for legitimate political action were either established, challenged, or diminished. It meant that issues of management, control, and structure were placed on the agenda of health care organisation. It was an appropriate means to investigate power in the health service because the changes, particularly the creation of new management structures, involved attempts to secure future abilities to maintain or to increase the scope of people's influence on health policies. Moreover, as this study will demonstrate, the 1982 reorganisation helped shape subsequent events and was itself a response to the many arguments which went on beforehand. It should not be understood as a single event brought about as a response to any particular problem. Instead it was part of a continuing political process.

Chapter Two
The National Health Service and power

In the first chapter, claims were made that the social policy literature once tended to be dominated by a functional/system approach which was reinforced by a tradition of empiricism. Indeed, to understand the 1982 NHS reorganisation as a past event, and therefore as no longer relevent, is to be locked in the functional/system paradigm. The reorganisation was not simply an attempt by government to resolve faults in the system of health care. While the 1982 NHS reorganisation happened as a matter of central government policy, it is also the case that different people perceived different problems and were either won over to the changes, convinced that they would do no lasting damage, or had no influence whatsoever.

This chapter examines the literature of the health service more closely than the first. The implicit conceptions of power in the health policy literature will be made explicit. This will demonstrate that since the post-war consensus on the welfare state has been challenged, the literature has had to move increasingly away from system models of the policy process towards a greater concern with conflict, crisis, and with power.

However, it remains true that a significant portion, particularly in the professional literature, accepts the earlier approach. The literature can therefore be subdivided according to discrete parts of the system that have been focused upon: the role of medical professions, nurses, and the bureaucracy in the decision-making processes. Another way would be to tackle the debates revealed in the literature chronologically. This would have merit in not separating the debates from the organisational and managerial

arrangements in the NHS as they developed. However, this would mean that consideration of the various political groups would be somewhat disjointed for the reader.

Consequently, this chapter is something of a compromise. The roles of various groups will be defined and described. Keeping repetition to a minimum, the responses of other groups in relation to these groups will also be outlined. This will suffice for the period before the Conservative government was elected in 1979. Developments since then will be tackled chronologically.

Definition of the NHS's problems

It is important to note that, despite the vigour with which the new government spelled out a new beginning in 1979, the Conservatives inherited a situation in which many problems were being defined. They were able to take advantage of a situation in which it was widely perceived that the NHS was in trouble. Observations made in both academic and professional literatures suggested many faults in the NHS after its previous reorganisation in 1974. (This was largely the work of a previous Conservative government, although joined the statutes when a newly-elected Labour government took office.) A Royal Commission was set up in 1976 which reported in 1979 and confirmed these observations. However, in accepting the case against the 1974 arrangements, the Conservative government elected in 1979, was acting in accord with its own definition of the problems of the NHS. In the year they took office they published the consultative document "Patients first" (DHSS, 1979). In this and elsewhere these problems were

expressed as an inefficient and overly-bureaucratic management that was costly and ineffective at making decisions. The almost universal disappointment with the arrangements established in 1974 was born of its inability to tackle the problems of coordination between separate branches of the NHS established in 1948. These had persisted for various reasons, at the heart of which was the separate development of different branches of the medical professions: hospital and general practice. The problems of the NHS had been expressed in terms of medical dominance. More recently, the relative positions of the medical professions and the bureaucracy within health care and elsewhere has occupied a central place in the literature. Because the medical profession's power has been more obvious and more documented, it is considered first. However, the powers of the medical professionals and the bureaucracies cannot be considered in isolation from one another.

Professional power

Doctors, as well as other professionals and the notion of professionalism, have historically enjoyed a positive image in society at large. The role of professionals was interpreted in most social policy analysis as the expression of society's concern and response in situations that require some collective action. Professions were defined as occupations according to certain "attributes" or "traits". Examples of this approach can be found in the writings of Barber (1963), Goode (1957), Greenwood (1965), and Millerson (1964). Greenwood, for example, listed five elements as the constituent attributes of a profession; a

systematic body of theory and skills, a prolonged period of training in order to acquire this knowledge and the profession's skills, an acceptance by the community of the validity of these skills and therefore the exclusive right to practise them, an ethical code, and a professional culture.

More recently, this "traits" approach has been rejected in favour of a "conflict" approach which defines professions as those occupations which have gained a measure of control over the determination of the substance of their work. Freidson (1970), defined professionalism as a form of occupational control. This has been justified and sustained by what he said was the "persuasive profession of the extraordinary trustworthiness of its members." Freidson (1970b, pxvii). Consequently, the uninitiated is excluded, not merely by the requirement of an education or training or some way of gaining expertise, but also by the requirement that they gain a licence to practice that is renewable, and controlled by a professional body.

Other explanations for the medical profession's ability to win their special status are available. Illich (1978, p50 or 1977, p17), for example, wrote that "a profession, like a priesthood, holds its power by a concession from an elite whose interests it props up". Illich argued that because professionals have claimed authority to determine patient/client needs, they have been able to combine sapiential authority to advise and instruct. The professions have a moral authority because such advice is obligatory. The professional "thus protects society's rather than the patient's interests" (1977, p18). Illich suggested that the

state prefered to hand over control on certain conditions, and it was these which made the characteristics of a profession important. Professions need the state to enforce their monopolies and licencing, and the state needs assurance that privileges will not be abused. Therefore, the profession must be organised and must recruit from trustworthy groups of people in society. While the service orientation of a profession and the adherence to an ethical code are important, so too are its social class background. Reinforcing Illich's view, Berlant (1975, p306) wrote that "a compatible constellation of interests", has to exist between professions and powerful social groups.

The acceptence of the conflict approach carries with it an acceptence that professionals are not necessarily benign in relation to patients and that professionalism is not necessarily a benign means of organising the services they provide.

Illich argued that people in the twentieth century are enslaved, or disabled, by the professionals or the experts because their needs have become legally or socially compulsory (1977). He said (on p24) that "The good citizen is he who imputes stapled needs to himself with such conviction that he drowns out any desire for alternatives, much less renunciation of need" and (on p27) "Life is paralyzed in permanent intensive care".

Most concern about professionalism, however, has been expressed in relation to the power they enjoy outside of the individual doctor-patient relationship. For, despite the individual basis of the work of professionals, they have successfully claimed to have expertise which can be used to solve social problems. They have

won the right to decide eligibility, individualise justice, and raise standards of health. Freidson (1970, p 98) said;

> "Given that the work of the medical practitioner is with individuals and that it is believed to be based on individual clinical experience, it follows that responsibility for the work can be perceived only as individual and personal. ..Given the risk of blame, he displays a certain sensitivity and defensiveness in the face of any outsider's evaluation of his performance. This defensiveness is manifested in imputing more uncertainty to the work than in fact exists and insisting on using his/her own personal, clinical experience as the ultimate criterion for evaluating his own performance."

Others have gone further than Freidson and in Britain have noted that the NHS is itself organised according to the branches of the medical profession. Crossman (1976) disliked the new district general hospitals for the way they were organised for the convenience of the consultants, the convenience of the patient and the family who wished to visit him or her were given a very low priority. Brown (1979) described the division of responsibility between health authorities and social service authorities as "the most serious impediment to the rational development of priority services". Brown (1979, p210) was not alone in noting that it is doctors' decisions which "effectively commit most of a health authority's resources". They write prescriptions and refer patients for tests and examinations. "Clinical freedom" has given them the right to prescribe whatever treatment they consider appropriate. They have, in effect, said Wilding (1982, p37) "a

blank cheque on the system, though it may not always be honoured."

The medical professions have imposed their medical model of health upon the organisation so that it comprised the health service's prevailing system of values. Butts et al (1981) concluded that the doctor-patient relationship ignores the population's health needs. Doctors, in preserving clinical freedom, fight for resources for "their" patients. The doctor-patient relationship has been valued as part of and as the product of an individualistic ideology, and in preserving this relationship the medical profession's ideology has been carried over into the organisation of health services where it has affected what might be more properly regarded as social or community concerns, and not those of individuals alone.

Ham (1982), demonstrated that the medical profession's power is not confined to its own autonomy and independence. In the area of social policy there are certain issues which have been ruled out from the discussions, for example, local authority control of health services. At the same time as the medical professions have enjoyed representation throughout the health service's policy structure. Doctors have long been represented in the highest levels of the DHSS, but doctors have also been represented on Regional Health Authorities (RHAs), District Management Teams (DMTs), DHAs, and District Medical Committees.

While no longer seeing the professions as soley benevolent, Berlant and Freidson viewed the growth of professionalism as functional to the requirements of the state, or whichever groups, classes, or elites have power within the state. A marxist

interpretation might suggest that the professions have been seen as instruments of state power, they have been useful to the state in that they render to government expert solutions at the expense of political solutions. They have viewed professions as those occupations that offered the expertise that the state requires in order to advise, manage, organise, and staff welfare services. The medical professions have enjoyed the sort of dominance within the health service that Clegg (1975) suggested.

Despite the different accounts offered to explain professional power, all the available political theories share an acceptance of its existence within the structures and organisations of the welfare state. Titmuss (1968, p196) made the point that;

> "in the modern world, the professions are increasingly becoming the arbiters of our welfare fate; they are the key-holders to equality of outcome; they help to determine the pattern of redistribution in social policy."

Challenges to professional dominance.

While the power of the medical professions has often been attacked in the past, a decline and its consequences were predicted by several writers after 1970. Johnson (1972) argued that professionalisation of occupations was the result of industrialisation. An increased number of people could afford professional services while industrialisation took place. As a small homogeneous number of people were in demand by a great many, the producers were able to impose their own definition of the

relationship on the consumer. He concluded that as the conditions which gave rise to professionalism are no longer dominant in industrialised countries, alternative forms of control might be relevant. Although he argued that mediation between the client and the professional by the state or by an enhanced role for consumer groups was possible and should be considered, he otherwise predicted a rise in bureaucratic power.

Mechanic (1979) also argued that a growth of bureaucratisation in health service provision was inevitable. Most medical treatments are poorly understood, but resources must be rationed otherwise there would be an unlimited capacity for the expansion of medical treatment: treatment which has tended to cost more because of its increased technological input or because chronic conditions have increased with consequently more treatments and of greater length. Interestingly, Mechanic made the point that increased bureaucratication has benefited the medical profession. No longer, as entrepreneur, have they to humour the patient. Physicians have become less dependent upon the patient, it has diluted their personal responsibility. Other interests than the patients may prevail, viz; research, teaching, or the public welfare (however defined). Mechanic predicted more specialisation among medical professionals in that they would gain more economic control, and could then dominate a specific domain. He also predicted greater differentiation between primary and specialist or hospital services as the result of moves towards specialisation. Doctors, he said, would be less able to advocate on behalf of the patient, will show less empathy, and less continuity of care would develop. The bureaucratic and technical

functions would be given greater priority. Despite the fact that doctors within bureaucracies were often humane in their treatment, there would be greater scope for the profession of medicine to concern itself with social control, by which he meant; the removal of misfits, containing deviance, and the encouragement of social functioning and productive activity.

Whatever the reasons for the attacks on the medical professions' powers, they have an institutionalised ability to prevent change according to Klein (1980). This view is supported by Heller (1978, p95) who argued that a switch of resources to primary care and to "cinderella" services;

> "cannot take place given the present power structure within the health service. The switch would be resisted by those powerful factions that have already distorted the system into its present shape."

All these comments must be seen in the context of the time they were written. The 1974 reorganisation, aimed at unifying the NHS's separate branches, established a bureaucratic structure with obvious costs and dubious benefits. Klein (1980) argued that the government's response to the problems of containing the costs of the NHS, allowing growth to be flexible, and maintaining the consent of the tax-paying population, was to build and increase an excessively complex bureaucracy. This came about, he said, because the NHS's finances have been highly centralised and have not been locally determined (unlike local authority social services). The DHSS bureaucracy had no interest in gaining more resources for the NHS; a separate local bureaucracy ran the

service locally, but has not been answerable to the local electorate (again, unlike local authority social services). He concluded that although this differentiated bureaucracy has been costly and adversarial, it has proved a cheap way of restricting demands and local budgets. The effect, he said, was that demand was shaped by the providers of the service. The local bureaucracy, faced with multiple objectives, no measures of efficiency, and no way of measuring the product, had to deny care to some. People qualified for care, not by right but, by reference to professional judgment. This form of rationing was, until recent times, said Klein, thought fair; the inadequacies of service that resulted were accepted. This paternal style of decision-making was able to shape attitudes towards health, but it depended upon a consensus between the medical and bureaucratic elites that he thought might be breaking down. Klein's argument was that it was government itself which had encouraged new external actors, such as Community Health Councils (CHCs) and trades unions, to counter the effects of an elite consensus on local health policy making. Klein concluded that, in maintaining the status quo as far as power and the distribution of health resources is concerned, a recognition of other health models than the medical model would inevitably incur additional costs. Nonetheless, Klein discerned recent changes in the abilities of other groups to exercise a veto on the decisions taken (1980, p120-23).

Klein was not alone in thinking that the previously accepted rights of the medical professions to determine health needs were challenged in the mid-seventies. Parry and Parry (1977) noted the emergence of union power in the NHS, particularly Cohse and NUPE, and of the attempts of "quasi-professions", especially nursing, to increase their status in relation to doctors. They said that nurses, unable to gain professional acceptance by the medical profession, appealed directly to the DHSS. Again, their argument supports Klein's in pointing to the role played by central government. The decline in union power under the Conservative government's privatisation strategy, also supports this view.

However, although there may have been an increase in the activities of those organisations that represent the consumer, and an increase in their numbers, the evidence suggests that their position remained weak. CHCs, for example, were established with veto powers on changes in use, but were reluctant to lose the goodwill of the medical professions and the bureaucracy on whom they relied for information (Levitt, 1980, p41). CHCs have had no executive or managerial functions and so have remained "toothless" forms of community representation (Elcock, 1982). In the USA, where the consumer movement has been stronger, self-help health groups have also tended to falter and stumble into a reliance on medical professionals (Boston Women's Health Collective, 1971).

However, while the formation of these bodies demonstrates an increased recognition of the rights of consumers to play a part, the greatest challenge to professional power during the 1970s came from the state through an increased bureaucratisation of the

health service. Before examining what the literature has to say about bureaucracy, it should be noted that Johnson (1972), Mechanic (1979), and Klein (1980) all speculated on the consequences of a relative decline of professional power. In sum, these amounted to a greater willingness and ability for administrators to be involved in decisions concerning the following;

a) eligibility for care

b) ethical problems

c) extending consideration by the NHS to include planning and consultation with local authorities

d) accessibility

e) shaping changes in demand for services, by the provision and funding of under-represented areas of service

f) setting of objectives and working towards them

g) conflicts with the professions, less concern for consensus

h) re-allocation of resources, taking initiatives, and the setting of long-term horizons, development of services, rather than building developments,

i) primary health care facilities and their development.

Predictions such as these have only seriously occurred since 1970. In a recent yearbook on the sociology of health, Roth (1980, pix) wrote that up until a decade ago, most writers in the sociology of occupations treated professional control as the norm. The extent of this change is indicated by Freidson's recent revision of his definition (1983). He has written that medicine has been joining the ranks of those modern professions which are distinguished by their technical, not their entrepreneurial, autonomy. He wrote of a movement towards important reorganisation of the profession as a corporate entity, while it would be too exaggerated to claim that these changes represent de-professionalisation. There has been, he wrote, greater control of the activities of practising physicians by that corporate entity, significant re-definition of the profession's relations with other occupations, its patients, and the agencies of the state.

As was seen earlier, most commentators on the scene in Britain have noted the importance of bureaucracy in relation to the medical professions' powers. Just how powerful the medical professions were perceived to be can be guaged from the descriptions avaliable - even as late as 1980 - regarding the power of the bureaucracy: the administration combined with local health authorities. As will be seen, the literature on bureaucracy has, like that on professions, become increasingly critical of bureaucratic powers. However, this criticism has a longer history. Consequently bureaucratic power has been re-defined many times.

Chapter Two
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Bureaucratic power

Weber's early conception of bureaucracy (1947) was of a rational, efficient organisation of statuses, characterised by hierarchical authority, division of labour on the basis of specialised competence, systematic rules, and impersonality. Weber recognised that no bureaucracy could be pure at its highest level where the position of authority is by appropriation, election, or designation.

Weber's definition placed bureaucrats at the opposite end of the occupational power continuum from the professions because it claimed workers in a bureaucratic work setting were bound by rules to which they must comply if they were not to lose the salary or wage for which they work. The individual was accountable to his or her employer and recognised that, if the employer was not satisfied, his or her services might be dispensed with. Bureaucracy as an idealised form of organisation, was one in which the employing authority has trust that its will would be done. Such a definition implied that administrators working in bureaucratic organisations have no power of their own.

More recent evidence suggests that bureaucracy does not work in this way. Blau (1955) and Gouldner (1954) have shown that the actual patterns of bureaucratic structure and operation are less rigid and more variable than the ideal type Weber outlined. Gouldner, for example, said that bureaucracies operate through rules that make power visible. These rules set minimum standards of behaviour, but the organisation allows behaviours that do not fall below these. Burns (1963) has since argued that industrial

development has progressed beyond the stage where Weber's idealisation of bureaucracy could be useful, and that efforts to make the bureaucratic ideal work have resulted in three "pathologies". Organisations have been reluctant to depart from the mechanistic structure, whose form is known as bureaucracy, and to adopt organismic structures.

A major source of variation occures when bureaucratic work goes on alongside professional work. Smith (1958) demonstrated the difficulties of a hospital organisation that operates two lines of authority, the administrative and the medical. Goss (1961), however, demonstrated that the two lines of authority were segregated. She termed the structure, an advisory bureaucracy, in which there was a dual system of control within a single hierarchy. On the medical side the physicians' individual authority was left intact, but they were obliged to seek advice from certain physicians whose competence was recognised. Those higher placed physicians were, in turn, expected to take an interest in the medical work of their "subordinate" physicians. Conflict was not apparent, and the supervising physician's advice was often unsolicited. Instead their advice was respected and regarded as helpful. Subordinate physicians were expected to review it carefully, but their decision remained their own. Gouldner's "representative bureaucracy" or Goss's "advisory bureaucracy" both developed from a concern that Weber's monocratic model of rational-legal bureaucracy has not proved an appropriate work setting for the professional, because professional's have insisted on self-regulation.

More recently and in Britain, Hunter (1978) claimed that the 1974 NHS reorganisation failed to take cognisance of the development of "matrix" (Weddell, 1976), "collegiate" (Golembiewski,1967), or "network" (Emery and Trist, 1973), concepts of organisation, and of "periphery-periphery, periphery-centre" models, as against traditional, "centre-periphery ones". So, in the context of NHS organisation, the traditional hierarchical model of bureaucracy has also been seen as outmoded and counterproductive.

Long before the rise of the "new right", *criticisms of* bureaucratic power came from the opposite end of the political spectrum. Galbraith (1967) drew attention to the growing power of big business and the deals they do with governments, thereby combining the concentrations of power which exist in the public and private sectors. Marxists such as Miliband (1969) or Gough (1975) argued that the growth of the state sector is indispensible to the extension of private industry. The pharmaceutical, building, and medical equipment industries are particularly the beneficeries of the NHS. Marxists claim that this explains why a government would wish to replace the power of medical professionals with bureaucratic power when there are so many similarities between the power of each over the populations they "serve" (Freidson, 1970).

More towards the centre, this has been much researched. Stanyer (1976) argued that local political systems ought not to be seen as an extension of national government and that each is a miniature political system. Their funds are secure, and they are isolated from market forces. Moreover local political systems

operate like one party states, rarely changing their political colour. They were influenced by the local social system, the local economy, and by local history. Stanyer's view was confined to local authorities which differ from local health authorities in important respects as health authorities have not been elected by a local electorate and have no power to raise local revenue of their own.

However, this view of the autonomy of local authorities is found in studies related to health services. Despite these important differences, Haywood and Alaszewski argued that local health authorities behave even more like the miniature political systems that Stanyer described because of their isolation from local accountability. Haywood and Alaszewski (p16) claimed that;

> "The assumption that the seeming legal, constitutional and financial dependence on central government meant little local room for manoeuvre has now been very effectively challenged. The interest in how local preferences arise and find expression in local authorities has not, however, been matched in the case of the NHS."

Haywood and Alaszewski (1980, p16) stated that;

> "...it would be unwise to assume that the seemingly greater financial dependence and the stronger constitutional position of the Secretary of State vis-a-vis health authorities means their room for manoeuvre is limited to what the centre will concede. Evidence suggests that their preferences are very influential, that they are able to act upon them in an effective way, and

central policies are not always given precedence when there is a conflict of priorities."

Haywood and Alaszewski suggested that, at the time they wrote, local health authorities enjoyed considerable autonomy. If so, then the "gap" between policy intentions and policy outcomes could be explained by the difference between national policy and local preferences which found expression through the relative autonomy of the local health authorities.

However, there is significant contrast between the descriptions given now to the role of the NHS administrator within the bureaucracy and those of, say, twenty years ago. In 1966, the Ministry of Health's philosophy was described as laissez faire: limited to the provision of advice and encouragement rather than direction (Griffith, 1966).

Reorganisation of both the National Health Service and the Ministry appeared not to have changed that philosophy to any marked degree until much more recently. Ham (1982), demonstrated that because the only control the Secretary of State possessed was to completely discharge the local DHA, there was no form of control that could be used for the normal management of DHAs. The locus of decision-making, within the global funding allocation, had been delegated away. Doctors enjoyed powers as major resource controllers. Policy making was local, initiatives were local, and DHAs did not have to accept Regional or National priorities, although RHAs are able to minimise local variations through informal means. The situation was described (Butts et al 1981) as one in which, although the Secretary of State had the ultimate

responsibility for the provision of health services, there was no practical means of controlling health authorities. Ministerial accountability to Parliament had no real meaning, but the convention of ministerial responsibility meant that local decision-making could not be allowed. Local autonomy of health districts was at odds with the principles of ministerial accountability to Parliament.

Haywood and Alaszewski (1980) described the relationship rather more closely and so demonstrate the point made in the first chapter that advantage in any power struggle is conditional. In situations of overt conflict the DHAs and RHAs were weaker than the centre. Central government's power was negative, it had only the ability to refer to norms and guidelines when local opposition was overt. However, AHAs and RHAs normally conducted their decision-making without having to justify their decisions to, or challenge, central government. When situations were normal, that is when there was no open conflict, managers, they said, "manage" the mutual adjustment process (p142). The managers' ability to act was highly circumscribed by the limited legitimacy accorded by medical professionals. Professionals did not accept a management hierarchy, and the bureaucracies were primarily engaged in conflict avoidance.

This notion of the health service's administration is confirmed by a study conducted at a similar time by Hunter (1979 and 1980). In his case study of two Scottish health districts, Hunter demonstrated the ways in which managers worked within existing constraints and balanced initiatives. Using various judgmental

strategies they maintained a consensus. However, their judgment was not based on any evaluation of the possible benefits of the expenditure of development funds. Instead they relied, entirely on "standard operating procedures". Judgments were made on the basis of fair shares, or of who has over/under spent, administrators asked who would be least hurt by a decision, who has done alright so far. The consequences that resulted from these processes were that the administrators reinforced the existing policy stasis, plans were limited to development of new buildings, the aim was appeasement, and the containment of conflict.

However, the acceptence of local autonomy in these accounts has to be limited because the autonomous view of local authorities is very hard to sustain in the light of recent trends (Cawson, 1982). These suggest that local county, borough, and metropolitan authorites have lost considerable powers as central government has tightened up on local spending and has been more rigorous in its enforcement of its tighter spending policies. Cawson's model was not limited to local authorities but also encompassed local health authorities.

The Conservative government of Mrs Thatcher pursued policies that severely restrained local authorities' ability to spend because much of their finance came from central government and not from local rates, through such means as cash limits and rate capping. Local health authorities rely for almost all their finance on central government and the government has also sought to influence local health authorities' spending through imposing controls on

medical manpower, annual reviews of RHAs and DHAs, as well as through the government's ability to select suitable chairs to the Authorities. Even more recently the government has assumed further powers by strengthening the "general management function". The people appointed to carry out this function will be accountable, to regional general managers and ultimately to the Secretary of State. Their accountability to DHAs is less certain. The next section looks at the thinking which has led to these developments.

Summing up the various accounts based on pre-1979 evidence, these saw the role of the administrator as limited to making decisions based upon judgments of cases presented by, or a balance between, competing interests. These were largely medical: the cogwheel system existed, as far as clinicians were concerned, for the purpose of getting doctors to meet and agree who should get what resources. It could be said that the role of the administrator was described as a "fixer" and not only by people outside the business of administration. The role of the administrator was described in the forward to a conference report as, partly as follows;

> "... the administrator should be an enthusiastic enabler helping individual doctors, nurses, and others to overcome problems in doing what they think best for their patients, and at the same time a dispassionate assessor of competing claims for scarce resources" (Paine, 1978).

When administrators did find themselves making decisions with policy implications, it was with some degree of reluctance. Halpern (1979) for example, quoted an AHA treasurer, "People are forcing us into political roles... you cannot say that you are in a simplified professional, managerial role. You are in a political arena."

As recently as the time of the 1982 restructuring, Harrison et al (1984), in conducting a pilot study of NHS middle management perceptions, found that initial attempts to get managers to talk about their objectives encountered considerable reluctance to think in such terms, the language of problem-solving had to be used instead. The results indicate that the role of middle managers in the NHS was "clearly one of servicing others rather than directing them."

Nevertheless, and despite any reluctance, the importance of the bureaucracy within the NHS had been increasing, since 1974. Klein, for instance, as was seen earlier, argued that this was of the government's making. The 1974 reorganisation of the NHS was intended to unify the service. The management arrangements set out in the "Grey book" (DHSS, 1972) were designed to enable involvement of clinical staff in management and so reconcile the delegation of responsibility with the need for Parliamentary accountability.

Alaszewski et al (1981), in writing about the 1974 reorganisation, claimed that the advice given to civil servants by the Brunel Health Services Organisation Research Unit and the consultancy firm of McKinseys systematically ignored the types of management

developed in industry and use "Burns and Stalker's model of flexible organistic [sic] management (1961)" as an example. In not understanding the power of the local medical workers within the mechanistic structure that was established in 1974, Alaszewski et al argued that the 1974 reorganisation had limited impact on both decision-making and the distribution of power.

So far, this review has demonstrated how the respective powers of the medical professions and the bureaucracy within health care have been defined. Medical professions were portrayed as dominent; administrators were portrayed as "fixers", serving the needs of others; and local health authorities were portrayed as largely autonomous from central government. Early challenges to the respective powers of professionals and administrators have been outlined.

The challenge of the "new right"

Since 1979, the powers of both the medical profession and the bureaucracy have been altered by the election of Mrs Thatcher's Conservative government. This government was committed to the values of the market economy and keen to apply market economy analogies throughout politics and social policy. While claiming populist support, its thinking was influenced by academics and others, known collectively as the "new right". The influence of Hayek (1960) and Freidman (1980) on the early ideological position of Mrs Thatcher's government was articulated as a justification for much that has happened since. By reorganising the NHS, it has had a significant impact on both professional and bureaucratic

powers.

During the period covered by this study, the government articulated its viewpoint with force and most of this has been directed at the bureaucracy of the welfare state. However, views on professionals have also been articulated. Bosanquet (1983) outlined what the consequences have been for social policy and the role of professionalism. He said that class similarities between professional elites and that strand of the Conservative Party that has now been termed the "old right" and which has lost some of its former influence within the party because of the rise of the "new right", are no longer thought sufficient to maintain the "constellation of interests". Where once it was proposed that society benefited from the existence of professional elites, the Conservative Party has come to regard professionals as merely a middle class varient of trade unions (Pappworth, 1984), and even more disruptive to the processes of justice inherent in the market (Bosanquet, 1983, p8).

In this, the "new right" might appear as not so very far removed from the thinking of Ivan Illich (1977). But whereas Illich was concerned with the harmful influence that professional organisation can have directly upon the individual, the "new right" appears to be more concerned with the harm that organisation, in general, can have upon the market which is seen as the guarantee of freedom for the individual. Freedom for the individual appears to be highly valued by the thinkers of the "new right", not because individuals will benefit from freedom as such, but because the "new right" believes society has always

advanced through the willingness of some individuals to take risks (and specifically not through collective or institutional action). Freidman (1980, p3) wrote;

> "the combination of economic and political freedom produced a golden age in both Great Britain and the United States in the nineteenth century".

The implications of this thinking are suggested by Green (1984) who claimed that the foundation of the NHS enabled the medical profession to counteract the effects of the consumers' voice, as expressed through the friendly societies and medical clubs which existed beforehand, and to secure higher payments through a third party, the state. This view ignores the necessity for patients to organise themselves in order that they would gain from medical treatment, and that such treatment was often inadequate. While similar views were expressed earlier by marxists and elitists, Green, and the "new right", down-valued the redistributive achievements of the NHS and its success in bringing decent medical care to people who were previously unable to afford it.

As stated earlier, most of the Conservative government's attention has been directed not at professional dominance in welfare but at the growth of bureaucracy and state monopoly power. The argument used was that power had continuously been concentrated in the hands of fewer and fewer bureaucrats and this resulted in a breakdown of the representative process. Demands to curb the power of large scale private sector organisations have resulted in government regulatory agencies: government has replaced one kind of concentration of power with another.

Mishra (1984), for example, has outlined the thinking of the "new right": its evaluation of the post-war state in general, and of the welfare state in particular, has been one of failure. Governments have failed to achieve policy objectives and this has been blamed, by the "new right" on the unforeseen and unintended consequences of government action and on the "naive collectivist equation of the common good with state action" (p34). The idea of "government overload" has taken its place in the thinking of the "new right": demands on government within the context of rising expectations and made by interest groups and have exceeded, by far, government's capacity to meet them effectively. The "new right", according to Mishra;

> "...is in no doubt about the source of current economic difficulties - it is the government, or more precisely the growth of government in the post-war years." (p42)

The thinking of the "new right" has obvious consequences for bureaucracy, even more so than its thinking regarding the professions. Conservatives have chosen to see state bureaucracies, not as mere servants of the public or as obedient tools of the politician, but as sectional interests in their own right. They have seen bureaucracy as working outside the constraints of cost-efficiency and competition. As a tool of government, presumably even a "new right" government, bureaucracy has to be regarded as much an evil of the welfare state as any other social organisation that interferes with the market economy. The government speaks positively of management and negatatively of bureaucracy. Re-labelling redefines the role of the bureaucracy.

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The primacy of the market has provided a new criteria for what is rational in social arrangements. This "rationale" has gone so far that it incorporates those social organisations that express the public's collective will in the market. The politics articulated by the "new right", including their re-definition of the proper role for bureaucracy, implicitly relies upon an extension of the dominance of economic values in society so that health policies become more closely related to the economic system. Regardless of the fact that the resources of the NHS have often been employed to counter or cure the effects of the British economy and its products on the population, it has been the stated intention of governments that the NHS should operate as efficiently as possible. This has long been one of the valued objectives for the "rational" management of the NHS. Butler and Vaile (1984, p140) claimed that efficiency "has been espoused enthusiastically as a policy goal by governments of both the major political parties". However, with the "new right", the term "efficiency" has been narrowed down to a single meaning of allocative efficiency - as used in classic economics' standard price theory. It amounts to a theory of markets, not a theory of intra-organisational behaviour. It is this useage of efficiency which has been taken up as an objective for rational decision-making and as a means of judging the performance of public sector industries and public services. The concern for economic growth has consequently produced a policy environment in which economic constraints act upon social policies (or non-policies).

So, "rational" choice in decision-making is not only deliberate and consisent, it maximises the utility of the individual making the choice or decision. "Economic Man" will settle for nothing less than the best that restrained resources will provide. An "economic rationality" is implied, even when rationality is acknowledged to be limited or bounded by imperfect knowledge of all the factors.

The economic gains in providing health service treatment, or of offering treatment, remain uncertain. The effects on health of activities justified by the needs of a modern economy are equally uncertain. The Growth Domestic Product (GDP) and its sustained growth are valued and so form objectives for a government. GDP and similar economic measures bring equivalence to the production of goods which include confectionery, tobacco, alcohol, and foods, and which may ultimately affect people's health. Despite the acknowledged difficulties of making financial comparisons, public services were regarded as a drain on the economy's productive sector by the "new right", and as also very expensive. The term "rationality" has been altered considerably by the limitations placed upon it by the thinking of the "new right". It has lost its meaning in both its everyday and its philosophical senses because of the economic assumptions made by the policy makers of the "new right".

In contrast with earlier NHS reorganisations, a concern for economy in the provision of the health services was uppermost. The consultative document "Patients first" (DHSS, 1979), which preceded the reorganisation, stated that the government's main

objective was;

> "to establish a structure for the Service which will enable health services to be planned and managed most efficiently, and within which decisions can be taken quickly by those who are close to and responsive to the needs of patients."

The effects of this reorganisation cannot, therefore, be compared with previous reorganisations except in saying that it had different aims to start with. Nevertheless, it is clear that people were frustrated and disappointed with the 1974 reorganisation and that the government used this.

Stoten (1982), writing of the period between the 1974 reorganisation and the subsequent one in 1982, said that the DHSS had adopted the rational model of decision-making, but that the lower levels of the NHS had adopted incremental, or mixed scanning approaches. The annual planning cycle was the mechanism by which the DHSS's rational planning approach to management was to work. By 1979 when the new Conservative government came into power, and the Royal Commission (1978 and 1979) reported on the working of the NHS, it was clear that the planning cycle, as a rational planning mechanism, had failed, with the notable exception of the single district authorities. Stoten claimed these had less difficulty in preparing consistant and coherent plans. They were able to focus on services as well as the development of capital plans, they were effective in reallocating existing services, effective in convincing the service that long-term horizons are necessary, and in widening the horizons of health service planners to incude primary health care, community medical care, and non-NHS

functions. A concern for planning, reaching objectives, and a wider view of health than the medical model was implied to bureaucracy from these expectations.

The Conservative government's took this point up and in "Patient's first" (DHSS, 1979, para 15) stated that most of the existing single district area authorities contrast with the multi-district areas in that;

> "their members can be more closely in touch with those who provide services to patients, and indeed with patients themselves, and the management arrangements are simpler and potentially more effective. This has led the Government to conclude that what is needed in England is a pattern of operational authorities throughout the service, similar in the main to the present single-district areas."

So, the virtues of single-district health authorities were central to the government's reasons given for reorganisation in 1982.

Moreover, the abolition of the AHA tier established in 1974 would lessen the numbers employed at that tier and make decision-making more local, so most people were more than happy to see this remote bureaucracy abolished. Its only defence in the literature was from Klein (1982). While he admitted that the two-tier system of officers was criticised for its duplication of responsibilities and consequent delays and administrative costs, he said that the two-tier system acted as a safeguard for lay authority members. With reorganisation, members lost their independent source of advice. In future, policy formulation and execution would be in

the hands of the same officers. The local bureaucracies, by this organisational change became more homogeneous, and more able to carry out their functions, as determined by the government.

One of the main contentions of this study is that the 1982 reorganisation, despite appearances to the contrary, strengthened the bureaucratic functioning of the service (with a consequent weakening of the influence of the medical professions upon policy making). Superficially, however, it appeared to be reducing the bureaucracy's powers because a whole tier of the administration was abolished. The government was, at the time, articulating the view that welfare bureaucracies were responsible for many of the country's ills. The reorganisation appeared, in making decision-making more local, to increase the powers of lay authority members, enabling them to be more active and more involved with the administration.

However, the proposition to be explored in this study is that while reorganisation in 1982 reduced the complexity of the administration and the numbers employed, the administration became a more effective tool for government. While much was said at the time about devolving authority to a more local level, little thought was expressed publicly about the authorities' and lay members' powers. This proposition is supported by Hunter (1984) who pointed out that since 1974 there has been practically no discussion of the position of members of health authorities. He argued that neither the Royal Commission on the NHS in its report (1979), nor the government in its consultation papers on the future shape of the NHS considered this matter and merely

endorsed existing practice. Hunter claimed greater awareness of members' difficulties was shown in a review (Royal Commission on the NHS, 1978) which demonstrated that more important than the arguments over election or selection, was the problem of whether members were able to perform satisfactorily the role prescribed for them and whether this was the role for which members were best suited.

So, the responsiveness of members to their locality was assumed but barely addressed in the reorganisation proposals. Instead, in stating the government's reasons for reorganisation - in "Patients first" (DHSS, 1979) - attention was focussed upon the administration. It said that the Royal Commission on the NHS (1979) had criticised the 1974 reorganisation because it had resulted in a structure with too many administrators and too many administrative tiers. There was a failure to take decisions, and the government wanted to make the NHS more responsive to patient needs. The government accepted, in "Patients first", the Royal Commission's criticisms that the 1974 structure resulted in;

> "- too many tiers; - too many administrators, in all disciplines; - failure to take quick decisions; - money wasted."

The reorganisation which the Conservative government planned for 1982 (and in which, incidently, the Royal Commission's recommendation for a chief executive was rejected), had four main elements; delegation of responsibility to local level, simplification of the structure, simplification of the professional advisory machinery, and simplification of the planning system.

The government's plans were implemented chiefly through circular HC(80)8, issued in July 1980, and entitled "Health services development, structure and management", (DHSS, 1980). Certain features of this circular need to be outlined here because they were subject to interpretation by the health districts used in this study. The circular set out the role, size and composition of the new health districts and determined that all the new authorities should decide on management structures, consisting of units of management. The circular contained guidelines for how these should be determined in paragraphs 27-34. Other circulars were issued which dealt with professional advisory machinery and the role of RHAs in implementing the changes. The guidance given in HC(80)8 gave districts wide discretion in devising their management structures and so provided an opportunity for examining alterations in power relationships within the local health authorities. It was a situation in which the internal forces shaping district management arrangements were to be as free as they were ever likely to be from external forces.

Examples of the types of units were provided in the circular;

" (a) A large single hospital.

(b) The community services of the district.

(c) Client-care services, for example, a mental illness with psychiatric community services and possibly the psychiatric unit of a district general hospital.... However, larger client groups may need to be divided into two or more units, ...

(d) The maternity services of the district ....

(e) An individual hospital, or group of hospitals, with the community services, that is, a 'geographical' unit.

(f) A group of smaller hospitals."

The basis of the units proposed in circular HC(80)8 was largely typified in the professional journals as either geographical, specialty, institutional or client-care group. In addition to giving to districts wide discretion in selecting the basis of their unit management structures, the circular left the degree of delegation of management to be decided by DHAs. Unit decisions, it said, should not necessarily go up the functional management hierarchies, but may be limited. Circular HC(80)8 strongly urged delegation but left the arrangements to individual health districts. For example, it said that unit officers should control unit budgets and exercise their responsibilities within the financial allocations and policies for virement between and within units set by the DHA. It said they should exercise this responsibility "in consultation" with a senior member of medical staff.

Circular HC(82)1 (DHSS, 1982) made provision for districts to organise their individual systems of representation of medical professionals. It specifically covered the arrangements for representation by general practitioners and consultants on DMTs. Other circulars were issued that made similar provisions for other professionals. See circulars DA(80)20, DA(81)7, DA(81)2, and DA(81)1, (DHSS, 1980b and DHSS, 1981).

In sum, the range of measures produced an environment in which delegation appeared to be the order of the day. Experience of the bureaucratic structure established after 1974 meant that people wanted to believe this. The actual proposals regarding reorganisation in 1982 encouraged them further. DHAs were to be free to end the functional chains of management which existed before. Districts were obliged to establish subdivisions called "units of management" and had to delegate as much day-to-day decision-making to units as was possible. Districts were to encourage virement both between and within these units and so the possibility was seen for units and districts to reduce expenditures in some parts of their services and retain the savings for other parts. At the time of the reorganisation, the role of the RHAs was limited to ensuring that the DHAs did, indeed, delegate their day-to-day decision-making to units (within certain prescribed cost limits). DHAs were free to establish whatever number of units and whatever kind of units they liked. Any mixture was allowed.

In the months immediately following April 1982, every administrator and nurse had to apply for their new job, and DHAs were obliged to enter into a re-appointments procedure that frustrated everyone for months. Nevertheless, the 1982 reorganisation was welcomed from almost every quarter, apparently in anticipation of a freedom to manage things at a local level according to local priorities. This can be seen in professional observations published in contemporary sources.

Before reviewing these sources, it should be noted that if authority had been delegated away from central government as much as some writers have insisted, then the local interpretation and implementation of the reorganisation would be in accord with local aims, not those of central government alone or entirely. If the "new right" model described above was not to be applied locally in entirity - or was to be added too -, then what models might be adopted? One of the aims of looking at the literature produced at the time of reorganisation was to answer this kind of question. It was essential to identify which models of management structure might coincide best with which models of health service provision and to identify these different models with the different actors.

The implications of reorganisation: the issues interpreted.

In order to reach their decisions, DHAs, employees, and professionals had to consider the implications, not only of the structure of units of management itself, and the reorganised professional advisory machinery, but also of maximising delegation, upon the way policy would be decided in the future.

During the period leading up to, and immediately after, the reorganisiation, seminars were held by health organisations, such as the King's Fund Centre, or at universities, often resulting in reports or in papers being published. Together with the articles appearing in the professional journals of both medical professionals and health service administrators it was possible to appreciate the thinking going on within health districts and among the professions.

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Most commentators reviewed here started out by stating what they thought the 1982 reorganisation was for. In this they display a fair measure of uniformity.

In February 1981 a seminar was held at Manchester University's Health Services Management Unit. The aims of the reorganisation in the minds of the people who attended this were reported by Allen (1981). He wrote that the 1982 reorganisation was an attempt to correct problems of the health service, some of which existed before the 1974 reorganisation, but also of the NHS after 1974. Doctors, it was said, complained of bureaucracy and slow decision-making and longed for the days of the "hospital secretary" who could get things done. The DHSS and ministers wanted improved efficiency.

Another important source to be reviewed here was a publication of the King's Fund Centre based upon workshops and a conference attended by "a large number of administrators and others" during the period February 1980 to February 1982. The publication was entitled "Unit management in context" and reproduced the papers presented. Future references to these papers will be identified by their authors' names - Armstrong, Fewtrell, Knowles and Dennis, and Millard (1982). These papers also display uniformity in what their authors thought the reorganisation was for. For instance, Armstrong (1982) noted that the 1974 reorganisation had been criticised, particularly by doctors, for the difficulties in obtaining decisions at both hospital and community level. Each of these papers express concerns related to delegation to units of operational (day-to-day) management decisions and the definition

of strategic management tasks which they said should be at district management level. The issue of delegation will be discussed further in reviewing the published perceptions of the administrators.

With the exception of Bussey (1982), nobody published any thoughts - at the time of reorganisation - on the problems local organisations might face in making their organisational decisions. Bussey summed up some of the difficulties and progress that had been made. He wrote that there had been insufficient time to think out the advantages of chosing an institutional, geographic, or client-care group basis for the composition of management units. DHAs were, he said, handicapped by an institutionally based management. The appointment of officers was delayed in many cases, while their advice was essential. Some of the newly appointed officers had no experience of the NHS, while some experienced managers had been lost. The role of the DMT vis the unit managers was also unclear, he asked "would the DMT be able to limit itself to its strategic role if the Unit Management Team (UMT) were unable to reach consensus?" The degree of freedom that UMTs were to have in "virement" was still to be settled. These problems of reorganised management were, Bussey said, still to be sorted out by many districts, having had little guidance from the DHSS.

The issue of medical representation

Although, no further guidance was issued from the DHSS after "Patients first", the role of clinical representative was legitimised in the 1982 reorganisation. It was a role also highlighted by Bussey in his article. The problems associated with it were used by the BMA to explain an announcement a year later, of a DHSS inquiry "into the extent of the duties of members of Unit Management Teams, and incidently an examination of how the teams are functioning" (BMA News Review, 1983).

Earlier, McQuillan (1981) wrote that the new structure would mean that more doctors would become involved in management team decisions. He recognised that the medical member of the UMT would share the team's corporate responsibility but that the individual responsibilities were unclear. The medical member of the team would retain the existing planning responsibility, and would be important in raising issues with medical staff. McQuillan saw the medical member being able to take urgent decisions on behalf of medical staff provided he met with them regularly and kept them informed. McQuillan also wrote of the problems of being an elected representative on a unit management team while, also being responsible to a district medical officer. He suggested that medical representation would work best when units were based on client-care groups because a unit that includes a hospital and its associated community services would have a greater motivation to resolve, and so reduce, conflicts. Bussey (1982) also considered the problem of medical representation, and asked how an elected medical representative could influence budget decisions when the

unit administrator and director of nursing services were both responsible to an individual on the DMT.

That medical professionals should be adequately represented in the re-structuring process itself was a further issue and was argued for by Dyson (1982) who drew attention to the increased pressures on resources brought about by the fall in spending, increased high technology medicine, and increased numbers of elderly with a declining commitment by families towards looking after the elderly. That districts should devolve to units was essential, he said in order that the problems of improving efficiency could be tackled by a management close to patient services. Doctors, he said, should influence appropriate unit boundaries, effective devolution, and adequate financial freedom. They should, therefore, choose to join the unit management "triumvirate".

The role of the clinical representative on the UMT was the subject of a seminar, attended by health service administrators, at the University of Birmingham Health Service Management Centre (Bluckert et al, 1983). Bluckert et al reported the results of questionnaire that showed that clinical representatives had received little training, and had little appreciation of the need for unit management groups to work in a formal manner. There was doubt over whether clinicians could maintain their loyalty to the unit, and they recommended a detailed review after twelve months. Some clinical representatives were not currently chairperson of the medical staff committee and, they said, this may lead to a conflict of interests between the representatives and the chairperson of the main consultant body.

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The issue of nurse management

Walton (1981), writing on the problem of re-structuring for nurses, typified units as either geographical, specialist, or more commonly as a mixture of both. In his view nurses work in a hierarchy which would, after reorganisation, meet at the level of the Director of Nursing Services (DNS)/Unit Administrator, but also at the level of the DMT's District Nursing Officer (DNO). His was a view that the UMT would act as a bar in the hierarchy, because of the ambiguity in the DNS's role as either a support for the DNO or as unit nurses on the Unit Management Team. In such a position the DNS might benefit from being able to advise the DNO and take part in the reviewing of and determining of nursing strategies, but might allow themselves to pass issues up as a defence against taking action themselves. Carr (1981), though he recognised that many combinations might be possible, proposed that units should be established by specialty so that DNOs receive advice from high quality from senior staff and would benefit from their expert knowledge. Carr said that the DNO would be a position of high importance as it would be at that level that the co-ordination of the nursing service would take place. Carr said that units should not, therefore, be based on institutions. He also recommended that units should be established for each district's community services, so that community nursing is separated from hospital based nursing.

Walton's concern was that of the delegation of responsibility and he was saying that, although the structure would be there to allow delegation, delegation would not happen if key actors in the

policy process chose to let day-to-day administrative issues be the concern of the DMT and its officers. Central to the concerns of the nursing profession is its status, particularly as measured against the medical professions. The nurse's role in management has been a key element in this debate since the Salmon report (Minister of Health, 1966). The 1982 reorganisation according to Levitt and Wall (1984, p204), appeared to have confirmed this role although it has since appeared to be threatened by the concept of general management.

Health service management: delegation to units

Delegation of responsibility accords with the fundamental tenets of modern management practice and was the prime concern of administrators who published their thoughts at the time. It is linked with one of the conventional wisdoms of "scientific" or "rational" management, as represented by Urwick (1965), that;

> "no supervisor can supervise directly the work of five, or at the most, six subordinates whose work interlocks".

This convention was taken up in the professional journals by commentators such as Sturt (1981), and applied to the management tasks that would apply after reorganisation. According to Sturt, the limited capacity for information processing and interaction between senior managers "generally lead to bureaucratic devices and control systems as aids to management". Hence larger DHAs would be likely, he predicted, to require smaller spans of control for district officers. This might require them to set up larger units, which would transfer the problem to unit level. Smaller

districts would be able to sustain a wider span of control, and so permit much smaller units.

In turn, this would affect the type of units districts would adopt. Again, according to Sturt, units based on functional division would reduce the possible span of control of top management, while geographically distinct independent units could be managed with a much larger span of control. The more delegation and autonomy granted to unit managers, the wider would be the possible span of control of district managers. Sturt also made a distinction over autonomy on issues that really matter, and the use of bureaucratic routines to manage supporting tasks and services. Where managerial authority could be freed from tasks that were instead standardised through routine or bureaucratic procedures, the less pressure there would be on the managerial span of control. So size, because it may hinder or help the strategic managerial task, might be a factor that DHAs considered in deciding the basis of their units.

At the seminar organised by Manchester University's Health Services Management Unit, the aims of the reorganisation were discussed (Allen, 1981, above) and the seminar also considered the basis of units, ie; whether they should be client-care based or geographic. Their thoughts on this issue were reported separately in a journal article written by Allen and Nichol (1981). According to the published report of the seminar, the issues which arose were;

a) delegation to units. The need for a uniform response across all disciplines at district level. The reluctance to delegate

b) the need to encourage staff at unit levels to manage their own affairs, yet to maintain control over district-wide policies

c) the need to appoint appropriate people to unit posts

d) what sub-unit structure would be needed.

They reported that doctors thought that the client-care based approach would;

a) strengthen the delivery and planning of care across the spectrum of care

b) strengthen the liaison between health care and non-health care managed services

c) fit more naturally the medical and nursing model of organising cinical care

d) fit more naturally, in some instances, the emerging patterns of para-medical organisation

e) facilitate a more single-minded approach to care with a higher staff commitment

f) reduce the problems of integration and, in consequence, reduces the co-ordinating demands on the administrator's role allowing him more opportunity to take up an adaptive/innovative management role

g) mirror policy and resource allocation at regional and national level.

The weaknesses of client-care groups as a basis for units of management were identified as;

a) it relies on future tentative developments in budget control and clinical costing

b) does not fit the model for organising hotel/commercial services which were geared to an institutional or geographic approach

c) makes it difficult to keep informed those who would not be represented on client unit teams as their work serves several client groups

d) disperses geographically the component parts of the patient care group.

The Manchester University seminar also discussed the problems of getting sufficient numbers of doctors involved, particularly as consultants apparently believed that they should have equal access to the district officers, and that giving control of budgets to doctors was seen as the "backdoor to economies" (Allen, 1981, p2).

For the King's Fund, Knowles and Dennis (1982) attempted to set out which activities could be considered as strategic management or the management of change and which could be considered as administration and operational management. They claimed that the NHS can, for the most part, cope with the operational management/

administrative activity with moderate effectiveness. This they defined as activities that include; maintaining, servicing, controlling, monitoring, directing, consulting, planning etc. The role of strategic management, they said, was lacking in both conviction and in effect. Knowles and Dennis defined strategic management as that activity geared towards meeting objectives for which there was a high degree of political consensus, for which there have been statements from successive governments, and which were enshrined in regional and area strategic plans and operational guidelines. They included;

a) the response to the maldistribution of resources, between regions, within regions, and between specialities

b) development of "cinderella" services

c) fostering of more community, non-institutional, care

d) expansion of services for the elderly to take into account the increased proportion of the elderly

e) control of doctor-initiated expenditure or the challenge of replacing ad hoc rationing systems with conscious rationing systems for health care.

Knowles and Dennis claimed that the lack of success in attaining the above objectives was not a failure of NHS managerial performance in relation to the processes of administration and operational management. It was a failure of management in relation to the task of strategic management. Most existing chief officers, they said, have acquired their posts on the basis of

proven competence in the processes of administration and operational management. Senior managers have remained rooted in these tasks, and consequently there was a managerial bias in favour of the status quo. This explained, they said, why the analysis of strategic issues was derived, not from NHS organisational objectives, but from the influence of dominant power blocks or vested interests at the local level. Knowles and Dennis argued that DMTs needed to make a conscious effort to delegate administration and operational management matters. DMT members, they said, will direct the process of the negotiation of change within the district and this will inevitably involve conflict and stress.

Millard (1982) predicted that DMTs might eventually make a more strategic style of management impact on the local health service. At unit level, he said, the task would be to engage in improving efficiency, monitoring standards, simplifying decision-making, and carrying out good personnel practice. In an earlier paper Millard (1980) argued that unit administrators will need to prove themselves in basic skills, by which he meant the ability to get things done, in order to gain the respect of senior nursing and medical staff, and that less help could be expected from the senior administration.

Fewtrell (1982), warned that the expectations roused in senior managers, staff, and public by the strengthening of unit management would be frustrated by the existing inertia within health authorities. National policy may, he said, dictate a formal change in structures and in the rules of the organisation,

but the reluctance to change, through informal day-to-day practice, might press the organisation back towards the status quo. He claimed there was little evidence of "spontaneous enthusiasm" for the policy of strengthening unit management within the service. So, local delegation and the strengthening of unit management would need a purposive evolution, through planning and training, rather than a radical revolution occuring on the due date in 1982. He also thought that the forces for a centralised district focus for management were potent, as DHA members might take a closer interest than the previous AHA members, and that the district focus of CHCs might draw DMTs into day-to-day issues. Furthermore, DMT members would be reluctant to move away from the area of crisis management and would be reluctant to lose control of present responsibilities. Fewtrell's concern was that the reluctance of health service managers to delegate administrative and operational management would continue regardless of structural changes, and he suggested that local health districts would need an explicit organisational plan to be phased over time to allow for training and changes in attitude.

Millard (1982) warned that a crude distinction between day-to-day administration and longer term planning might soon be divided into the two principal tasks for unit and district officers respectively. If this were to happen, he said, the new structure would get the worst of both worlds; a two-tier system with district officers losing too much contact with operational management and unit managers disinterested in the development of their organisation. He suggested that where units are based on "service" criteria it would be relatively easy to relate the work

of health care planning teams to the management arrangements, but that otherwise such teams might need to operate across units. He also said that, in the same way that plans are made for services, it is equally important that each unit would have its own plan.

Independently of the King's Fund conference, Nichol (1981) claimed that administrators would favour a unit structure based on clinical services, but that medical and nursing professionals would favour a unit structure based on patient care groups. A structure based on clinical specialties, he said, would cause problems in the integration of care, especially when non-NHS services are involved, and that the patient care approach would enable the single-minded approach across specialties favoured by the emerging para-medical professions. Its weaknesses would be that it would rely upon tentative developments in costing and budgeting, reduce the management time spent in institutions, would not fit hotel/commercial budgeting, disperse geographically, and would not fit some community services. Nichol said that there was a need to balance the requirement for comprehensive care planning against the requirement to delegate decision-making to the lowest level. This would be complicated because some services, such as non-clinical services like laundery and catering, were best managed at unit level, para-medical services require flexibility and were best managed across the district, and that nursing was typically a client-based hierarchy. Some services, such as diagnostic services, were best organised regionally. Unit management, said Nichol, was an attempt to respond to complaints from the medical profession that decision-making was too remote from local services and should be based on hospital and community

services. These complaints arose during the 1970s when the need for an overview to management resulted in the 1974 NHS reorganisation which centralised decision-making on policy and resources to the AHA level, planning had then taken place at a level above the hospital or clinic.

The paper for the King's Fund by Armstrong (1982) was primarily concerned with delegation to unit levels, and what degree of delegation would be appropriate. He drew a distinction between a planning and policy-making role and between an operational or day-to-day administrative role. This distinction was evident in the thinking published in journal articles and papers around the time of the reorganisation. Armstrong, who was at the time of writing his paper, an AHA District Administrator, argued that units will need "formal" meetings with agendas and minutes, and therefore "some bureaucracy", to record decisions taken when the team is undertaking its planning or policy-making role, and that the day-to-day management should be left to the appropriate individuals. Such a distinction can be interpreted as an attempt to define the limits of the arenas of legitimate action for the district bureaucracy.

Aside from the seminars and conference papers described here, a paper was published by Kinston and Rowbottom (1983) who were among the Brunell University theorists so influential in shaping the 1982 reorganisation. An excursion into what they said after the reorganisation is justified at this point. According to their school of thought, there are levels of work that only certain officers are capable of, and that only the larger districts will

be able to attract such people. Thus, size becomes a determinant in the issue of management responsibility, particularly at the strategic planning level (level 5). Many specialised skills and technologies can only be planned and provided economically, they argued, to district-sized populations, and therefore each unit should be devised to serve the population of the district. So, the division of units on a geographic basis would be "problematic". When small units (operating on level 4) were geographically based and made up of hospitals combined with community services, they doubted that the community services would get the attention called for by national policy. While they accepted that client-care based or specialty based units could be argued for on the grounds that they are output-oriented and able to facilitate planning, they argued that the existence of large district general hospitals in districts would mean that the institutional basis for deciding unit structures would have to be considered. A "levels of work" analysis has been applied since the 1982 reorganisation by Kinston (1984) who concluded that each health district should decide whether its services were to be run on level 4 or level 5, but that the "resulting mixture should be seen as a transitional state to one in which all Districts will operate with Chief Officers at Level 5." He recognised that levels of work in structures could be undermined if officers and authorities were not delegating or taking responsibility at the appropriate levels. Consequently the structure could be undermined by personnel calibre, personality, managerial style, planning methods, staff development, participation, high trust climates, attitudes of efficiency and equity, and an ethos of

service to the community.

Kinston's final two sentences are worth quoting in full for the way in which they demonstrate a political ideology and allegiance. He said;

> "Decisions will continue to be subject to political pressures and dominated by values and beliefs, but if a suitable framework exists, those pressures and values will at least be channelled. This is all that is possible in a pluralistic and democratic society."

This statement illustrates features common to much of the literature reviewed in this chapter and which has been so influential in the development of the NHS. The notion that decision-making can be and should be devoid of "political pressures and demands" is obviously a source of regret for its adherents. As was argued earlier, beliefs and values are "political" concerns, and therefore threaten the rationality of decisions which adherents of this view consider should be technical. In adhering to a "rational" (ie: non-political) model of "decision-making", a choice is made to ignore the political nature of their own thought. The "rationality" demanded of rational decision-making model is generally limited to the suspect notion of economic "rationality" used to model human choice-making. Coincidently, perhaps, it serves admirably the purposes of politicians of the "new right".

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The perceived issues: a commentary

In sum, the different perspectives provided by those writing and published at the time of the 1982 reorganisation were broadly as follows.

From the doctors' viewpoint the issue was primarily that of medical representation. How would elected medical representatives truly represent the medical profession when, as members of management teams, they would also develop team loyalties in addition to their loyalty towards their particular specialty? Would not involvement in management take doctors away from their prime concern of patient care?

Although these questions represent the way in which the doctors' views were expressed at the time it would be reasonable to interject here, that doctors foresaw problems in influencing decisions in a unit management structure for two allied reasons. These being firstly, that with a decision-making structure that had a high degree of delegation they would be unable to gain access to the District Administrator (DA) or the DHA members because anything that was not a strategic decision would be referred down the structure. Delegation is a way in which an administration can pre-empt decisions by making strategic policies as a skeleton on which other decisions must be built. Second, doctors on UMTs would find themselves up against other team members, the unit administrator and nursing officer, who had district officers they had to report to, and to whom they were responsible. The UMT's consensus would, therefore, be subject to the approval of non-clinicians.

Incidently, the issue of medical representation was on the agenda of discussion as a result of previous criticisms. Professional advisory machinery was being reviewed by a Chief Medical Officer's working party. This reported on 12th January 1981 and, as a consequence, the government published circular HC(82)1 in January 1982 (DHSS, 1982).

Few authority members write journal articles, although some do attend conferences. Only Fewtrell commented on the position of the authority members at the time of reorganisation. He suggested that, after reorganisation, authority members would be able to take a closer interest in the work of district officers, and that such an interest may even extend down to unit officer level.

From the viewpoint of the NHS administrators the issues were those of strategic management and the planning of district health services. How could district level officers take up strategic management tasks when few of them had the appropriate experience and training? To what level of the structure could administration and operational management be limited? The problem for administrators and management, although stated generally in these terms, would remain the same as before; how to manage an organisation efficiently and how to control expenditure when doctors retained so much of their power to commit expenditure. No explicit attempts were made to interfere in those areas where doctors power was supreme, prescribing and deciding upon their patients' treatment. Nonetheless, one of the main conclusions of this study is that this would eventually be one of the results of restructuring.

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With few exceptions (for example, Harrison, 1986), health service policy analysts have generally said little about such notions as domination, organisational and cultural ideological values, or Lukes' third dimension. This can be seen in the literature reviewed here. Such notions were not part of the vocabulary of those writing in the professional journals at the time who tended, instead, to write in the same "decision-making" terms as before. Some of the features of "scientific management" will be apparent from the review undertaken here. They occupy a place in the thinking and, therefore, the organisational culture of parts of the NHS as well as its external advisers. The dominance this gave to the issue of delegation meant that comparatively little thought was expressed in the literature about alternative objectives and strategies. Thinking about the possibilities for integrating services for particular client-care groups - a key objective during the 1974 reorganisation and which many recognised had not been its result - found no support among the administrators writing in professional journals at the time.

The government attached great importance to getting the structure and management of the NHS "right", despite any suggestions made that massive reorganisations might be counterproductive. The 1982 reorganisation generated a considerable body of thought and literature, as well as considerable managerial efforts and so management structures were clearly seen as important by people writing at the time and by those involved. It was through the "getting right" of structures that they thought the efficient working of the bureaucracy of the NHS depended. Most commentators made a fairly straightforward distinction between strategic

planning and day-to-day decision-making, although Kinston and Rowbottom (1983) attempted to define these limits in other ways, by detailing five levels of work. This suggests an organisational and professional consensus on the levels of responsibility and the action appropriate to bureaucratic and medical interests. They thought that people at certain levels within the structure must work at an appropriate level. Such views fit the ideal or model consensus of efficient rational bureaucracy. Furthermore, strategic contingencies theories influenced their view of organisations, and of power within organisations.

The literature published at the time of reorganisation was dominated by the issues of (administrative) delegation and (medical) representation. The basis on which units of management, as set out in HC(80)8, was considered only incidental to these two dominating issues. Nevertheless, this issue was important because particular basis were in accord with particular models of health service organisation and reflected different interests. These basis are generally referred to as geographic, institutional, client-care group, or functional specialist. The adoption of client-care groups as a basis might have encouraged the integration of care across hospital and community boundaries. Integration of services had been a major aim of the 1974 reorganisation. It had failed to happen then and consideration to client-care based units only appeared on some agendas in 1982: nursing and medical.

The literature reviewed here shows that administrators did not favour units based on institutions or client-care groups. Their concerns meant that units of management based on services for geographic areas were preferred (Knowles and Dennis, 1982, Allen, 1981, Gourlay, 1981a, Sturt, 1981, and Allen and Nichol, 1981). Medical staff, whether medical or nursing, tended to favour units of management with different bases than those favoured by the administration. Their concern was, not so much the efficient and rational decision-making processes that concerned administrators, but their own ability to determine a health service that would fit their model of health service provision.

None of the writers reviewed in the literature above suggested that nurses would prefer any other basis than that of client-care groups (Allen, Nichol, Knowles, and Hancock). The nursing profession saw advantages in forgetting the walls around the institutions (Carr,1981). According to Nichol and Allen writing of the Manchester seminars (attended by clinicians) the client-care basis was one that also would fit the medical model. The reasons given for this preference were that it would allow a single-minded attitude of care and would ease integration of care in single speciality hospitals.

The presence of large institutions could not be ignored (Kinston and Rowbottom, 1983), and some writers assumed that institutions would form the basis of units (Strick et al, 1981) It was also claimed that "units" meant "hospitals" to doctors (Knowles and Dennis, 1982). Dyson (1982) supported this view when pointing out that there are complex problems in large district general

hospitals when other bases are used for units of management.

The division of districts into units of management by either geographic or functionalist/specialist principles appears to have been unsupported by any of the medical or nursing professionals writing during the period. Only two of the writings published at the time expressed any favour towards division by function or specialism (Knowles and Dennis, 1982, and Nichol, 1981).

Reorganisation in retrospect

In the introduction to this chapter, it was said that the 1982 reorganisation might now appear irrelevant because of subsequent developments. Few foresaw the possibility that the government's stated policy intention to delegate decision-making and devolve authority might be overtaken by measures with centralising tendencies that would occur later. These included; annual reviews, performance indicators (DHSS, 1983a), and pressure for clinical costing techniques to be developed.

However, as an event the 1982 reorganisation was important in transforming the decision-making structure and the managerial culture of the organisation. The increased emphasis on management responsibility at unit level and the removal of a tier of administration made developments possible that, when completed, constituted a pattern of management in the NHS which was analogous to commercial or industrial management practice. Although this was foreseen by at least one commentator in the academic literature (Alaszewski et al, 1981) it was clear to commentators

writing in the health service literature only at a later date (for example, Steele, 1984).

An important part of this transformation was the limitation of DHA power. Evidence of this will be presented later in this study. It is also supported by other studies written since 1982. In an unpublished report, Charnley (1983) concluded that DHA members were manipulated by the DMT which was able to influence policy making through its planning strategies; presentation and handling of issues at meetings; the use of sub-committees to "test the temperature of the water and get members' reaction to way things should be presented in full Authority"; the development of informal relationships; the offering of choices that prevent the Authority seeing itself as a rubber stamp, while not damaging the intentions of the DMT; the allocation of specific tasks to members giving an impression of involvement; and through its considerable amount of control over the agenda. Charnley's study demonstrates that, soon after DHAs were established, the role of DHA members appears to have changed little from that of the old AHA members, as once described by Klein (1982).

Haywood (1983) published the first indication of what the new DHAs were concerned with, in a pilot study of six DHAs. He found that non-organisational issues were regarded as the most important issues raised at DHA formal meetings, even in the early months of reorganisation, and that financial constraints were the most important. There were unaccountable differences between chairmen, members, and officers, in what issues were seen as most important. Haywood's pilot study, without contradicting the conventional view

that health authority members are dominated by their officers, concluded that the reasons for this which are conventionally believed (the lack of prerequisites for power: electoral legitimacy and caucus behaviour) has yet to be validated. He suggested that changes in the way DHAs organised themselves might make a noticeable difference to the influence of chairmen and members.

Perhaps the most significant feature of the 1982 reorganisation was the general willingness to believe all the government said in respect of the delegation of decision-making to a local level. This probably arose from a number of factors. Among them was tne knowledge that the needs of individual health districts varied enormously. Some DHAs were responsible for budgets approaching 100 million pounds and serving populations of over 200,000 people while other DHAs were serving equal numbers with half the resources. Some DHAs had to cut their expenditures according to the Resource Allocation Working Party (RAWP) formula while others needed additional expenditure to provide facilities for their expanding populations. People generally perceived and were frustrated by the unnecessarily bureaucratic complexity created by the earlier reorganisation of 1974. The 1974 reorganisation did away with hospital based administrators and matrons and replaced them with a structure in which claims for resources went first to district officers (such as Chief Nursing Officers) who, in their turn, took them to Area based health authorities who had their own teams of officers. Area teams of officers were seen to be altering district proposals, often replacing them with ideas that had already been rejected at district officer level. Doctors were

finding that requests for even the most simple decision to be taken were being answered six months later, and often to their dissatisfaction. While doctors complained over excessive delays in getting decisions taken and attributed this to overly bureaucratic structures, clinicians retained all their old power of veto on consensus decisions.

This recent history must have predisposed people to believe all the government said and that delegation of decision-making was to be the order of the day. By 1985, however, when the interviews for this study were conducted, all this had changed. Soon after reorganisation, manpower targets were reduced for districts, independently of their financial limits. Annual reviews of performance were announced. There were also to be scrutinies looking for wasteful expenditures. Because they were more local, DHA members were now more able to scrutinise the service and the chairpersons were all new ministerial appointments. The government announced that DHAs would have to put their hotel services out to tender. Most significantly, even before all unit administrators were appointed, an inquiry was announced on the 4th February 1983 into the management of the NHS. The inquiry team was charged with the job of giving "advice on the effective use and management of manpower and related resources in the National Health Service". As if to add oil to the flames, the government announced that the inquiry team was to be led by Roy Griffiths, whose management experience was with Sainsbury's supermarkets.

So, within a year of the reorganisation, it became apparent to many people within the service that local decision-making was going to be determined by national priorities. While there were people who saw no contradiction between the 1982 reorganisation and what followed, there were many who clearly felt a great sense of disappointment. They explained what they saw as a governmental about-face with the replacement of Patrick Jenkin with Norman Fowler as Secretary of State. Fowler, they believed, had no intention of going through the grilling and castigation that Jenkin had suffered from the House of Commons Public Accounts Committee in 1981 (Public Accounts Committee, 1981).

Disillusion was concentrated on the findings of the Griffiths management inquiry. The BMA, for instance, gave the report a cautious welcome initially but continued with sporadic objections. In November 1985, for example, the BMA protested to the government's chief medical officer that 28 DHAs had decided to drop medical officers of health from their new boards of management (Guardian, 1st November, 1985). The effects on the nursing profession were even more marked and the Royal College of Nursing (RCN) mounted a publicity campaign - with an overall campaign budget reported as 1.5m pounds - (Dunn, 1986) against the way the inquiry's recommendations were being implemented by DHAs in January 1986. By this time, however, most District General Managers (DGMs) were already in post.

While the Secretary of State claimed that the implementation of the Griffiths recommendations would not amount to a reorganisation and, indeed, no new legislation was required, the changes it

brought about were highly significant. The Griffiths inquiry recommended that the NHS adopt the general management function throughout its organisation and that general managers be appointed for regions, districts, and units. It is too early to evaluate its success but the appointment of full-time professional managers with responsibilities for the development of services might end the long tradition of voluntary management, as well as consensus management.

As was demonstrated earlier in this chapter, the ability of medical practitioners to block decisions all the way up through the organisation of the NHS was believed to be responsible for much of what was wrong about the health service. This belief was supported by the social policy literature. The implementation of Griffiths might, therefore, be interpreted as an attempt by government to deal with one of its major problems; that of how to limit the capacity of the medical profession to determine health service provision within the NHS. While no attempt was made to reduce significant areas of medical power (the clinicians' right to decide who would be treated and how, remains unaffected, for example) several other areas of medical power were to be curtailed. The GP's right to prescribe drugs was, for example, curtailed but much more significant was the way that the profession was excluded from the committee structure of health districts because general management resulted in the abolition of consensus teams that previously had seats reserved for their representatives. Also under the Griffiths reorganisation, the government gave considerable encouragement to the budgeting or costing of identified clinical specialties. Not all districts

were able to implement this and often were only able to do so in limited form. However, its successful implementation might enable doctors to see where their expenditure is greatest and might make it possible to hold clinicians to account.

So, instead of viewing the 1982 reorganisation as irrelevant because of the subsequent reorganisation that followed the Griffiths management inquiry, it is possible to see these events as just episodes in a transformation of the NHS. The reorganisation of 1982 was the essential precursor to subsequent events. The results of this study will show that the 1982 reorganisation allowed a strengthening of the administration's position by first making "inefficient management" its target. In an earlier section of this chapter, a contrast was remarked upon, between the way the administrator's role was seen before the 1982 reorganisation and the way it is seen at the time of writing. The 1982 reorganisation, while appearing to be a response to demands for a reduction in bureaucracy, actually encouraged the administrators to take on more power. The question of whether this whole strategy was intentional, or whether it happened merely as a result of political decisions conducted in line with Conservative Party doctrine, is outside the scope of an empirical investigation. However, the government appears to have succeeded in an attempt to change the way people within the service think of administrators. They were no longer to be seen as servicing the needs of medical providers, but as managers. Under such conditions, clinicians were encouraged to take responsibility for their expenditure, and it became common-place for doctors to be questioned over things, like the length of patient-stay, that

would never have happened earlier. The study will show how the 1982 reorganisation successfully disrupted the medical power lines. These changes together, as well as subsequent developments, enabled the general management function to be introduced later. The government, in "Patient's first" and elsewhere, denied that the idea of a chief executive figure would be pursued but, if the 1982 reorganisation is viewed as a precursor to this event, then it suggests that plans to introduce the general management function were firming up just as the 1982 reorganisation was taking place.

This view is open to competing interpretations and must remain the subject of some contention. First, it might be argued that Conservatives simply saw achieving cost-efficiencies as the major problem. This view is not incompatible, for cost-efficiencies could not be achieved, in the thinking of the "new right", unless the power of the medical providers was tackled first.

Second, this view might be challenged by asking "If the government planned both these reorganisations, why did they not implement them both together?" One answer to this question is suggested by government statements, that at the time of the 1982 legislation (as well as earlier in "Patients first" and the report of the Royal Commission) the proposal for a chief executive had been rejected on the grounds that professional interests needed to be protected. More significant perhaps is the fact that new authorities were to be established in 1982 and, for the sake of continuity, the expertise of officers and officer teams needed to be retained at least until such time as the new authority members

had gained some experience. Only then could the consensus teams be replaced.

Last, this view would be challenged by people following the same reasoning as Taylor-Gooby (as outlined in the first chapter), in which it is argued that, despite the ideological posturing of the Conservative government since 1979, no real change has occurred (1985). Klein has argued along these lines specifically in relation to health policy from 1979 to 1983, in an article subtitled "the retreat from ideology?" (1985). His argument was that the government had been faced with "conflict between reality judgements and value judgements" and that this was resolved by the victory of reality judgements, although the retreat was camouflaged by "a smoke screen of political rhetoric" (p190). Klein concluded that the administration's concern to contain public expenditure has "lead it into a reversal of policies in the NHS, contradicting its original ideological position". The fault with this reasoning was that an objective reality, based on the same source of statistics that government used to defend its record on the NHS, was taken as evidence to deny that an ideological advance has been made. The two are quite separate. It could as well be argued that the presented facts of increased spending camouflaged ideological advances. In any case, Klein's argument was built on the government's performance over 1979-83 and this study covered a different period, although they overlap. Power, as discussion in the first chapter, operates at several levels. One of these, is at the level where people in an organisation, such as the NHS, are unable to articulate their interests, or even to think what those interests might be (see

p26). This is what has been taking place in the NHS and the articulation of an ideology is as much an act of power as is a decision to increase or reduce health expenditure. Far from there being an "ideological somersault", the new right's ideology persisted.

As Klein acknowledged in questioning the "retreat from ideology" argument, the principle of consensus management was "defended" and the proposition that each district should appoint a chief executive was rejected in 1979, but adherence to these principles was completely turned round by 1983. Actual expenditure can only be compared validly with what another government might have spent or with the proportion expended before the government took office, not with their ideological position. Klein also noted a change in direction away from the government's earlier commitment to devolving power to more local health authorities towards accountability to Parliament. "..., as the four years went by," he said, "less and less was heard of strengthening the responsiveness of health authorities to the local community" (p200). Yet, in 1982, with the establishment of more locally-based health authorities, there was less reason to expect to hear that kind of rhetoric. Surely a switch back to more accountability and good management rhetoric was what should have been expected and its occurance cannot be taken as a "retreat from ideology".

The strengthening of the administrator's role, accomplished in the 1982 reorganisation, was a necessary precondition for getting around the anticipated medical objections to ending consensus

management. Once doctors, administrators, members, and nurses began to accept the "managerial" role, rather than the "administrative" role of officers, then the previously acceptable, and therefore legitimate, manner of decision-making, in which doctors could block the necessary consensus, could be replaced by another. The weakness of health authorities also helped to establish a position whereby administrators were increasingly allowed (and required) to manage. By 1985, general management was an idea that was fast gaining legitimacy because DGMs were in post, and so it is reasonable to claim that the Conservatives, under Mrs Thatcher, have shown themselves far more adept in dealing with the problems of medical dominance than any previous government.

If the introduction of general management is successful in this, and there is every indication at this early stage that it will achieve acceptance, then the government's achievement must be regarded as a remarkable one. All the more so because, in transforming the NHS's management culture, people's awareness of their changed roles must have resulted in stresses and anxieties, additional to any opposition they might otherwise have felt towards its purposes. The changes being brought about in 1985 and after could only have gained acceptance, however reluctantly, because the government succeeded, in 1982, in achieving a strengthening of the bureaucratic functioning of the organisation and a corresponding weakening of the medical profession's abilities to influence the organisation of health care.

Chapter Three
Research design

Introduction

In the first chapter, attention was directed towards the problems encountered in researching power. It was noted that conceptual problems of power were often connected to how power could be identified and researched. It was shown how "decision-making", "non-decision-making", and Lukes' "third dimension of power" were each misconceived notions of power which, in different ways, relied upon empirical tests. It was argued that power operates in many and various ways, only some of which might reveal themselves through empirical manifestations. These manifestations were themselves affected by the operation of power.

Then, in the second chapter, it was argued that the 1982 reorganisation of the National Health Service (NHS) could be studied as a manifestation of power which would be broader than state or governmental power alone, and include the power of individuals and groups of individuals, such as professional groups, but which would still be subject to those limitations apparent in the first chapter. That is, power was not to be conceived as merely the ability of some people to influence decisions. Instead, it was conceived as something which was the ability of people to think, to articulate, to accept, and to respond to other peoples actions (including their speech actions). Its manifestations were not to be confused with power itself.

In the second chapter, research was reviewed which suggested that the organisation of health care has been dominated by the medical professionals, although some writers detected a relative decline in medical power. This led to a consideration of the 1982

reorganisation of the NHS which the Conservative government of Mrs Thatcher introduced as a response to its perceptions of the problems of the NHS. These problems were not expressed in terms of medical dominance of the organisation but as the result of an inefficient and overly-bureaucratic management that was both costly and ineffective at making decisions. A different government might have seen the problems differently and enacted different solutions. Chapter Two then described the formulation of opinions, and concepts within the literature, both professional and academic, that concerned the reorganisation. Some coincidence was shown to have existed between the views expressed and the professional background of the people expressing them. The review of literature of health service policy undertaken in the second chapter demonstrated that the empirical misconceptions of power described in the first chapter informed much of this writing.

This chapter takes up where the first chapter left off in discussing the anticipated methodological problems of a study into the manifestations of power during the period. It describes the criteria that were adopted by which the evidence examined was to be interpreted. It then describes how these problems shaped the formulation of the research objectives and the strategies that were devised for gathering and interpreting the empirical evidence. Lastly, it describes how the results were interpreted and written.

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Methodological problems

These methodological problems were twofold. First, there were those that related to the selection of data which would provide evidence of power. The nature of power relationships can mean that the availability of the empirical evidence may be unrepresentative and politically misleading. (The limits on the availability of evidence might constitute "self-selection".) For example, in the literature reviewed in the second chapter it was seen that the opinions and views that were selected for publication could not be assumed to represent the opinions of all those people involved. The absence of any expressions that were representative of the opinions and desires of health authority members was also noted. The problems associated with the "selection" of evidence, and what was done about them, will be described more fully with the description of the gathering of empirical evidence that comes later. They are distinguishable from the second set of anticipated problems outlined in the first chapter which arose from consideration of how far the evidence, itself, could be representative of power.

The objectives and aims of the study

Organisational decisions, such as the 1982 NHS reorganisation and the establishment by districts of unit structures, were selected as suitable areas for the study of power in the NHS because they were perceived as decisions that would affect all aspects of health service provision and the way future decisions would be taken (or not taken) and problems perceived. The establishment of

unit and management structures in health districts (HDs), and the range of decisions that had to be taken, were decisions, quite simply, required of the District Health Authorities (DHAs) by central government. They would affect future working relationships. They were important evidence for a study of power because people with power would be seeking to affect future power relations within their district organisations. It was intended that the study of the process and outcome of organisational change would reveal changes in the perceptions of "subjective" interests, at the very least. ("Objective" interests could not be measured by changes in perceptions.)

It has been argued, previously, that an understanding of power within the NHS required an understanding of the organisation's culture. Consequently, as was stated earlier, the study was planned to make it possible to arrive at an understanding of what meaning was being given to the concepts and terms that had currency at the time of reorganisation. The study attempted to examine the ways in which people perceived the 1982 reorganisation and its potential for dealing with their perceived problems. The NHS, like any social arena, has its own organisational culture which employs concepts peculiar to itself. If situations were to be represented adequately, then they would have to be reported as ideas or attitudes that were authentically held before proceeding to further analysis which might demonstrate in what respects they were true or false. To criticise ideas or attitudes as false, or to say that interests were "subjective" and not real, was not to deny that they were held or that they have had consequences. The study was intended to reach an understanding of the

self-understanding of the political "actors" of the organisation.

The empirical study was conducted in two phases. The first phase was an examination, analysis, and interpretation of the formal or documentary evidence that related to the establishment of DHAs, unit structures, and management arrangements. The second phase was a survey conducted among key identified actors in a narrow selection of health districts. The study was intended to explain historical events which would never be repeated. So, there was no need to select health districts from a perfectly stratified sample: the survey was not intended to provide explanations of events with any predictive powers.

Each phase had its own objectives, and its own methodological problems, but they were planned in conjunction with each other to meet the overall objectives of the study outlined above. Partly this was so that the evidence established could be verified but the major reason for this was that the objectives of each phase complemented each other: both phases were necessary for each other.

The documentary evidence that was examined during phase one, despite the limitations which arose from the purposes for which it was produced, allowed those to express their intentions and concerns within, to some extent, their own terms: the formal constraints of health authority meetings. These constraints were different from those they might feel while taking part in a research interview. While possible to take these documents at face value, revealing a decision-making world in which decisions were arrived at after reasoned debate and after due consideration

of all the relevant facts, they could be interpreted in other ways. A comparative approach was planned for phase two that would make it possible to add to the initial interpretation.

Phase one: the formal documented evidence

The first phase of the study comprised an examination and analysis of formally recorded evidence surrounding the 1982 reorganisation. This was limited to a consideration of the evidence that was available in the SE Thames and SW Thames health regions. It was planned to include all the relevant minutes and agenda papers plus any other documentary evidence that DHAs were prepared to make available, such as those produced for consultation within their district organisations. These were obtained by requesting them from the District Administrator (DA) of each of the health districts in the two regions. The offices of the two Regional Health Authorities (RHA) were also visited. Here it was possible to examine all the documents that were submitted to the RHA for approval. The minutes of all DHAs were also stored at the RHA's offices and, where the DHA had not been able to respond to the request for these, they could be examined there. There were several reasons for undertaking this phase and these were as follows.

First, if power (in any of its many senses) was to be studied, then the things that people did in order to wield or maintain power must have had some significance. Power is not always covert: it can, at times, be used openly over whom it is wielded. Openness assumes an importance, to those with power at the very

least, if only as a constraint. Specifically, agendas and minutes were required to be produced and to be made available, for a whole variety of uses, and it was thought that those who were involved in producing them, (and that includes their attendance at the meetings of which the minutes formed a record) were doing so with some purpose. The requirement to be open about decision-making may act as constraint on those with power but it can be more than that. It can be extremely useful, in defining roles, because of the reputational aspects of power. Power can be distributed among, or attributed to, those people who were seen to perform or behave in accordance with openly identifiable and powerful roles. Briefly, if someone was seen to have an interest and was seen as able to represent that interest effectively, then power might be attributed to that person in future. Issues can be kept off agendas by the very people whose performance in public places, such as at public meetings or in recorded minutes of decisions, was seen as powerful.

And second, it was essential that the documentary evidence be examined *first in order* that an appropriate survey strategy be devised. The documentary evidence would suggest further questions and enable the definition of appropriate categories for comparative study. Interviews would have been meaningless without a prior examination of health district records. Any survey that included statements of opinions, attitudes, or of recollections of events should be corroborated by any written records still available.

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Inherent difficulties of the documentary evidence

The initial idea for using agenda papers and minutes as documentary evidence of power in the NHS came from "Tracing decisions in the NHS" by Barnard et al (1980) which was itself based upon a feasibility study commissioned by the Royal Commission on the NHS (1979). The editors introduced their report of the study by concluding that tracing specific decisions back through records and minutes;

> "is an effective way of studying the decision making process, but time-consuming and not without methodological problems." (p5)

The first, and most important, of the problems anticipated by Barnard et al was the difficulty of defining a decision and determining when a decision has taken place (p20). This was a difficulty of method, very obviously connected with the theoretical and conceptual difficulties outlined in Chapter One.

A further problem, foreseen by Barnard et al in 1980 concerned the choice of tier from which the decisions were to be sampled and traced. This problem no longer existed by the time the research was being undertaken because the 1982 legislation had abolished Area Health Authorities (AHAs), and because District Management Teams (DMTs) had begun to function in specific relation to DHAs. In order to test the retrospective approach, the Royal Commission had suggested (according to Barnard et al) six types of decision which should be examined, however none of these were concerned with an organisational decision, such as was the intention of this

study. Organisational decisions may have been on the increase but remained comparatively rare.

Barnard et al (p87) finished their feasibility study with a note of warning to future researchers;

> "...the "tracer" issue approach only covers those issues which have been allowed onto the management/authority agenda and are the subject of record. Issues which key actors have the power to keep off the agenda will not be picked up. This assumes great significance, signalling the need for a different direction to the research effort if other evidence suggests that this frustration of the will and aspirations of other groups is a major cause of the perceived discontent and disquiet over the National Health Service."

This meant that the tracer approach could not be used alone. It necessitated the second phase of the study. However, it was decided that the tracer approach would be useful as a beginning in the overall project of investigating power in the NHS.

The documentary records of health authority meetings posed several additional problems which varied in their complexity concerning a) their bulk, b) their timing, c) their language use, and d) their partial nature.

a. Each district produces an extraordinary amount from which to select. Most records did not relate to organisational or management concerns but had to be sifted through in order to pick out where these issues were discussed.

b. Some single district health authorities had existed before the 1982 reorganisation, but most DHAs came into existence in 1982 and replaced AHAs at the same time. Several DHAs existed in "shadow" form since the later half of 1981. Minutes of these authority meetings were not always available. Also by the time that this study was being undertaken several districts claimed they had mislaid or destroyed their records.

c. Complex problems arose because of the language in which DHA meetings are recorded. As will be seen, the nature of the language used was a key feature of the analysis to be attempted. If the data, the language in which meetings are recorded, were to be read in the "natural" and "obvious" way, then Health Authority minutes would have presented the decisions as "non-theoretical" and self-explanatory. In Chapter One, it was noted that it is because of the common sense view of language as "natural" that it has been overlooked in the study of power in social policy and organisation theory.

The language used is important to any understanding of power because power rests on consensus, much more than on coercion, and consensus can be gained when language acts as a symbolic order in which people think about what their interests are. It is the essence of argument and persuasion. For instance, the recorded minutes of DHA meetings are produced in the third person. The effect is to present things as reality rather than as a personal interpretation: the minutes and records are depersonalised. Their purpose is to present an account of reasoned decision-making, not to reveal the exercise of power.

DHA meetings, because they are recorded and because their membership is made up of a variety of interests all able to speak, resemble the pluralist notion of democracy. Members are appointed by RHAs, not elected. In this resemblance they are, like language itself, a symbolic representation. The minutes and agenda papers recreate the image of democratically accountable local decision-making. The image was created, and re-created, because of the visibility of what is commonly termed "decision-making". Their representation as a record of decisions taken, after reasoned debate, re-affirms commonly-held and cultural beliefs that power is spread in a pluralistic fashion and may disguise concentrations of power.

Minutes and agendas, in their final presentation, may omit alternative arguments in many cases and only present the "deciding" arguments behind the adopted decisions recorded.

The problems for empirical research, associated with language use and the partial nature of the record of decisions, were those of how to understand the social structure and the way it had structured the decisions and ideas that were visible. Consequently the observed evidence not only had to be recorded and analysed, but also had to be interpreted. The criteria used for arriving at interpretations have been discussed earlier at the end of Chapter One and apply to both phases of the study.

d. The incomplete nature of the documentary evidence means that the decisions taken within health districts as to how the issues would be decided, and who would take a leading role, would only be partially visible. Such a decision would only be visible

when the health authority had decided to request that its DMT or a group health authority members consider the issue. Only then would the decision on the decision-making process be recorded in the minutes. A record of the presentation of proposals by, say, the officers could not, necessarily, be taken as meaning that the initiative had come from the officers. While, the officers, in this example, might have been acting on their own initiative, it could not be assumed that they were.

Several DHAs considered the reorganisation as sensitive and had treated the issue as confidential. In order to obtain such papers, undertakings were given that the health districts, the DHAs, and their staff, would not be identifiable. Thus, each of the DHAs in the two regions were assigned a number so that they could be refered to individually in reporting the research. While the amount of information varied, minutes of all the authorities were examined, and relevant agenda papers obtained from all authorities except DHAs 2 and 4. Seven DHAs (3, 4, 5, 8, 17, 21, and 27) considered some part of the issue confidential. Consequently, in these DHAs the reorganisation appears to have been discussed at no great length because the DHA was "in committee". (DHA 17 refused to send any documentation because the reorganisation had been considered "confidential", however, the RHA offices held most of this district's papers.)

Despite the inherent difficulties of the documentary evidence, it was possible to collect an enormous amount that related to the formal recorded decisions. The analyses and the initial interpretations that led to the design of the survey are described

in Chapter Four.

Phase two: the survey

The documented evidence could not be used alone as it revealed only an unrepresentative part of the processes: the role of informal discussion was omitted yet may have been crucial in the process. Actors' views cannot always have been determined at the point at which they were presented for formal consideration. However, even informal conversations, about which there is little evidence, could only have been conducted within the assumptive frameworks, or organisational cultures, prevalent within the NHS. While documented agreements have legal authority, spoken agreement might have paramount significance. The second phase of this study, a survey conducted by interviews, was to be conducted in conjunction with the comparisons made of the formally recorded decisions. Its prime purpose was to get behind the formally recorded evidence and obtain further information about the events and the organisational culture of the period. The interviews were to be subject to conditions of confidentiality and, therefore, there would be no reason to suspect the interviewer was being deliberately misled. Interviews would reveal what the people involved thought had taken place as well as their own attitudes to those things as best as they could recollect them. (Although, of course, some of the events were three years in the past and, without doing so deliberately, respondents might mislead through having forgotten or rationalised their intentions of the past.) Leaving aside the methodological refinements that went to make the

survey more representative and less prone to problems of recall, the purpose of the survey was to establish a record of what people involved thought (wrongly or rightly) had gone on. The survey was planned in such a way that it would allow a description of the "actors'" own interpretations of the events to be made. Health authority minutes would not allow this type of description because of the necessity for the minutes to form an agreed record.

The survey was preceded by two pilot surveys that revealed many instances where respondent's recollections did not concur. Part of the purpose of the survey was to examine where there were points of agreement over what had happened, but also to understand why recollections might differ.

The survey was also planned to make it possible to reveal the opinions and desires of others not represented in the documentary evidence.

The survey's research questions

The research questions arose directly out of the analysis of the documentary evidence and the interpretations offered in Chapter Four. For instance, the documentary evidence revealed variations in the degree to which health authority members had been involved in the decisions taken. The role of health authority members had not been revised in any of the legislative changes in 1982, yet the way they were to work in future would be affected. The survey was planned to examine these changes in more depth than an examination of the documentary evidence could have done. The

ability of officers to restrict or to include health authority members in the decision-making arrangements was identified, in the documentary phase of the study, as crucial to any growth or diminution of their powers. Such changes in the capacities of administrators to act like this would be related to the varying capacity of medical professionals to influence events. Therefore, the survey was planned to allow an examination of the possibilities that had also existed for medical professionals to influence events, if not through their direct intervention, then through the knowledge of medical reaction.

Future roles might be influenced by present perceptions, or uncertainty, of those roles, and the survey was intended to allow an examination of this kind of interaction. People would have planned management arrangements that amounted to organisational changes partly because of their beliefs that some things needed to be changed and partly because of their perceptions of what were "legitimate interests" in the organisational structure. Therefore, it was necessary to ascertain those things which people were committed to change.

These were questions that could not be addressed by a reading of the minutes and agendas of DHA meetings and associated papers because such formal documentation of meetings function partly to confer legitimacy on both the structure and the overt processes of decision-making. Views of organisational culture could, however, only be expressed through a framework of the respondent's own making. It was this mental framework that was itself of interest, not some framework of the researcher. So although accountability

and delegation, say, may have become research interests, it was respondents' beliefs that these were issues or the priority attached to them, that shaped responses to the problems of their district in formulating unit management structures. It was this that determined the interviewing and questioning strategies adopted.

Interview strategy

The interviews were designed, as far as possible, to allow the respondents to talk freely about the issues as they saw them, using the terms they preferred to use while keeping to an agenda of topics that the researcher hoped they would cover. To this end, the interviews were conducted in an atmosphere as relaxed as possible (and frequently accompanied by coffee and biscuits). The interviews took place in the respondent's office or clinic, although some health authority members were interviewed at home. The interviewer dressed in a way which would not look out of place, and attempted to hide his political sympathies by wearing a blue suit and a red tie. Instead, he stressed that his interest in the 1982 reorganisation was born of other long-standing and "non-political" interests in the NHS. The interviews were conversational in tone, although conducted in a business-like manner. The interviews were preceded by personal assurances of confidentiality and the respondents all agreed that the interview could be tape-recorded in order to prevent the necessity for the interviewer to take notes. Respondents were asked to assess the impact of the 1982 reorganisation upon their health district, the

way people had worked together during the reorganisation and after, and the way that the district had been able to alter its provision of services as the result of the changes made. The interviews took place during the months June to September, 1985; some three years after the 1982 reorganisation and while health districts were implementing the general management function. In fact, District General Managers (DGMs) had been appointed in each of the four health districts by the time of the survey. This meant that respondents were caught up in sweeping organisational changes and many questioned whether the 1982 reorganisation was still relevant. However, the 1985 changes meant that many districts had recently reviewed their unit structures and management arrangements and many respondents were able to compare their present arrangements with those established in 1982 and, thus, say things about the earlier organisational structure. It was intended that the responses would be revealing not only in themselves but also in the way that the questions had been understood by the respondent. The study was intended to examine how the organisational culture had enabled people to, or prevented them from "realising" their interests, expressing them, and acting in support of them. The broad question to be addressed was that of how people within the service were able to influence the decisions taken during and since the reorganisation of 1982. If people have power or influence within health districts, to whatever extent, how have they adapted their strategies for being influential since 1982? What was it they felt they could or could not do, say, fight for, or resist both during and after the reorganisation? What forms of action or thought were permitted?

And what "mode of rationality" operated to direct or influence thought or action? It was thought that respondents would not be able to respond directly to such questions. The answers would have to be arrived at through a later interpretation.

The questionnaires

The range of questions was required to be different for each of the key actors interviewed. These are presented in the appendix although they were not strictly adhered to. They should really be regarded as agendas for discussion rather than as questionnaires in the strict sense. The questions, or prompts, were arrived at from the analysis and interpretation of the documentary evidence. Where there were inconsistencies or gaps that were not accounted for in the documentation, questions were framed to elicit the respondent's opinion or recollection of the events.

The interviews were intended to get each of the key political actors identified to describe how they had each perceived the process of reorganisation and change. They were asked to describe the government's intentions in reorganising and state how they each regarded the outcomes. They were asked to give their views on what they had personally regarded as desirable of the reorganisation. They were asked questions intended to get them to describe whether they thought they could work within the present organisational "system" as satisfactorily as beforehand. In relation to their part in the process of reorganisation, they were asked what matters they had attempted to influence in the development of the structures. They were then asked if they

regarded these matters as crucial to their role and their own work. They were also asked if reorganisation, unit bases, and management structures were regarded as significant. Lastly, they were also asked to talk about how they regarded the 1982 reorganisation in relation to the changes made since 1982 (annual reviews, performance indicators, specialty budgeting, and general management). In many of the responses, the interviewees took the opportunity to describe how the reorganisation had resulted in policy changes and new ways of working.

Selection of health districts

The intention of the second phase was that it should be an exploration of the events and the processes at work during 1982 and after in order to attribute explanations to the outcomes in terms of different power relationships from what had gone before. This decided that the change in the organisation's "deep rules" or its culture was to be the crucial factor. The second phase was to be designed to uncover what socialisation processes were used in district organisations in order to ensure accommodation to the changes being made. As there could be no direct comparisons in arrangements between the AHAs and the DHAs which had superceded them, it was decided that the basis for comparison would have to be between those health districts which had or had not been able to establish units of management whose basis was a radical departure from the functional management arrangements that had gone before. Health districts were not simply conservative or radically different in the way they made their structural

arrangements but a distinction had to be decided upon. While "radicalness" could have been decided by, for instance, the degree of delegation of power downwards, this had to be rejected because delegation might have been determined by other factors, such as the size of the pay-roll (particularly for small units) and the abilities of individual managers. It would also be subject to change after 1982 in individual units. Initially conservative arrangements might eventually be altered to radical ones over the period covered by the study. The basis on which units were determined was decided to be more open to study because, although existing institutions could act as a determining factor, the basis of the units of management were visible indicators of a district's determination to alter its provision in favour of certain client groups. Under the arrangements that had existed before the 1982 NHS reorganisation, management structures corresponded to institutions and functions and were not subdivided by patient groupings (except where these coincided with institutional provision). Thus, it was decided that those districts which had established that at least half their management units would be client-care based would be included in the category of districts where radical change had been instituted. Any remaining health districts would be counted in the conservative category. This, of course, paid no account to the relative size of each of the units in any particular district. However, it was decided that size would be a difficult thing to establish. Pay-roll, bed numbers, or finances could each be taken as a measure of size, but would be inadequate as a measure of the size of a health service. In any case, relative sizes would be likely to alter following

developments during the period of the study after 1982.

The documentary evidence, examined as phase one, suggested that DMTs (or officer teams) may have decided upon radical change in some districts and that in order to then achieve their desired objectives may have sought, by differing degrees, the involvement of their health authority membership and chairperson. The documentary evidence suggested that the role of health authority officers had changed from that of being a "fixer" for the medical professionals who directed health service policy, as was described in Chapter One. Nor were they seeking, in the way suggested by Hunter (1979), a balance between competing claims on health resources. They had taken on a much greater directional role in conjunction with health authority members, particularly chairpersons. The ability of officers to adopt a stronger directional role was possibly constrained by, among other factors, history, the present resources of their particular health districts, the local strength of organisation of trades unions or professional bodies, and the personalities of the local political actors. The documentary evidence revealed some correspondence between those health districts that opted for more radical structures and the extent to which DHA members were involved in the formal decision-making process. This correspondence between the kind of change and health authority members' involvement made the latter a significant factor in any explanation that might be suggested by the survey. This led to a decision that the survey would also be designed to make it possible to make comparisons between those health districts where health authority memberships had or had not been involved. This meant there would be four

distinct categories of health district to be selected for inclusion in the survey. These were;

a. those where members had been involved and where radical structural change had taken place (five health districts)

b. those where members had been involved and organisational change had not been radical (ten health districts)

c. those where members had not been involved and where significant structural change had taken place (one health districts)

d. those where members had not been involved and organisational change had not been radical (ten health districts)

(In addition, there were two health districts where the evidence was insufficient and it was impossible to tell where members had been significantly involved or the extent of change.)

In reporting the results of this study, conventions were adopted to ensure anonymity. For the sake of brevity the use of "DHA" is confined to the District Health Authority in its formal sense, and not to any of its officers and staff. To ensure anonymity, all health districts in the two regions were assigned numbers. When the whole health district is to be referred to, it is referred to as HD 1, 2, 3, etc.

Chapter Three
Research design

After the analysis of the documentary evidence, districts were grouped according to the categories outlined above, thus;

a) HDs 20, 23, 24, 25, and 28	b) HDs 1, 2, 10, 12, 13, 17, 18, 19, 22, and 27
c) HD 6	d) HDs 3, 4, 5, 7, 9, 11, 14, 16, 21, and 26

The intention was that the second phase should include districts of all kinds (at least, of those that differed in these two major ways). So, one district from each of these categories was selected for the second phase by a random process. These were HDs 6, 7, 12, and 23. In Chapters Five and Six, which describe this second phase, each of these districts is referred to by a pseudonym (respectively, Heathdown, Milham, Dunhurst, and Wimbury). In describing the first phase, the same system of numerical identifiers is used for these districts as is used for the others. The selection process excluded those two health districts noted above (HDs 8 and 15) which were difficult to categorise. (HD 15 was used, however, in helping to develop the interview strategy.)

The DA in each of the selected districts was approached with a request that people in the district be asked to take part in the survey. In each case, this approach was successful and this was, in part, because the survey was preceded by a pilot survey using two other health districts on a pilot survey basis. The DAs approached could, therefore, be assured that the interviews would not be overly-indulgent of the respondents' time. The respondents

might also have been more assured that confidences would be respected and that the interview situation would not be personally threatening. The two pilot survey health districts (HDs 15 and 20) were used quite differently. The first was a collaborative enterprise between the investigator and the trial district (HD 15). Meetings were arranged during which the topic and research interests were talked about. The people involved were able to suggest strategies that they thought would be acceptable to their equivalents in the districts to be used ultimately in the survey. They helped to ensure that the prompts to be given in the interviews would be comprehensible to the respondents and would be interpreted by them in a way that would be useful to the research. The second district (HD 20) was used to pilot the survey. Interviews, here, were conducted in a way that was fairly close to the way they would eventually be conducted. This resulted in data that was analysed briefly to ascertain whether the approach developed was likely to yield useful information in a form which could be analysed. This analysis forms no part of the results described in Chapters Four, Five, Six, and Seven.

The selection of respondents

The documentary evidence examined in the first phase suggested that either the individual principal officers, the DMTs as a whole, or the health authorities' membership had deciding roles in the reorganisation of the health districts. This led to their selection for interview. However, it was not possible to

interview all the membership of the authorities. It was, therefore, planned that interviews should be limited to the chairperson of each authority and one other member. The member was, in each case, suggested by the present DA whose co-operation was required for the survey. This means that they might not be representative of the membership as a whole, the only selection criteria that was available to the study being that the person should have been involved from the beginning of the authority's functioning.

DMTs usually include a GP and a consultant to represent primary and hospital medical opinion. While they do not have any line management responsibilities, they do form part of the management team. To balance the opinion of doctors in such management positions, it was intended that an interview would be sought with a doctor who could speak for professional interests without being part of management. This, however, was not always appropriate because the organisation of medical representation was not uniform. Where in one health district the consultant member of the DMT was a different individual from the person who chaired the District Medical Executive Committee, in another district he was the same person. In yet another district there was no body equivalent to a medical executive committee. Even where doctors held positions that might have made their assessment of the 1982 reorganisation valuable, they were not always able to spare sufficient time. This was made more difficult because the person acting in such a capacity was not always the same person who had been acting in that capacity three years previously (a problem not unique to doctors, of course). Nevertheless, in each of the

selected health districts it was possible to see at least one clinician. Doctors were also represented in the person of the District Medical Officer and the GP representative on the DMT. Nurses were represented only by the Chief Nursing Officer in each district.

The people, therefore, interviewed in each selected district were as follows;

HD 6 (Heathdown) District General Manager (District Administrator at the time of the 1982 reorganisation), District General Administrator (Deputy District Administrator at the time of the 1982 reorganisation), District Medical Officer, Deputy Chief Nursing Officer, District Treasurer, Chairperson, Vice-chairperson, a health authority member, the consultant representative on the District Management Team (who also chaired the medical executive committee), the General Practitioner representative on the DMT, (and the Chairperson of the Joint Staff Consultative Committee).

HD 7 (Milham) District Administrator (and the ex-District Administrator), District Medical Officer, Chief Nursing Officer, District Treasurer, Chairperson, a health authority member, the consultant representative on the DMT, the General Practitioner representative on the DMT, and the chairperson of the Hospital Medical Executive Committee.

HD 12 (Dunhurst) Chairperson, Chief Nursing Officer, District Medical Officer, District Treasurer, the consultant representative on the DMT (who also chaired the Medical

Executive Committee), the GP representative on the DMT, and a health authority member. The District Administrator had not been in post for more than a year and was not formally interviewed. The previous District Administrator had retired and could not be interviewed.

HD 23 (Wimbury) Vice-chairperson, Chief Nursing Officer, District Medical Officer, Assistant District Treasurer, Chairperson of the Medical Executive Committee. The District Administrator was not willing to be interviewed but instead offered someone who had assisted him at the time in detail. This person, who was now a deputy unit administrator, was interviewed.

Only in HD 6 (Heathdown) was it possible to see someone as head of the staff side of the consultative committee. The responses given in this particular interview would have been valuable if the research had been into an altogether different area (such as staff morale since 1982), but was not considered useful in reaching any conclusions about the way organisational "deep rules" had been altered by the 1982 reorganisation. It was, therefore, considered necessary to discount this kind of evidence. (The only conclusion it appears possible to make is that union organisation in the NHS has been damaged considerably and that this may have resulted from the unsuccessful pay-dispute in 1982 and, more latterly, the effects of competitive tendering.) While unions may have been consulted in 1982 and may have had interests to pursue that might have affected the management arrangements of health districts, by the time of the interviews, they were no longer in a position to

state what these interests were and to assess the impact of the 1982 reorganisation of the NHS upon the organisation of individual health districts.

Recollections of the 1982 reorganisation

By the time of the survey, DGMs were in post in each of the four health districts. In HDs 6 and 23 (Heathdown and Wimbury) the DGM was the previous DA, while in the other two districts, new people had been appointed. The newly-appointed DGMs had set in motion some alterations to the structures established in 1982 and sometimes there was confusion when respondents were being interviewed. Obviously this confusion was cleared up at the time of the interview but the fact that it arose serves to illustrate that many respondents were caught up in present events and saw the 1982 reorganisation as past history. In one interview, a Chief Nursing Officer's recollections of the 1982 reorganisation was so clouded by present worries that she confessed to be being able to remember very little about it. Nevertheless, that interview was exceptional.

The four surveyed health districts

The four health districts surveyed were chosen by a random process having first been divided into distinct categories. In the first category, those health districts which had adopted radical structures and where the authority members had been involved, was HD 23 (Wimbury). In this district the authority members were

involved in the process because they attended a day "workshop". There were six units established in the district, two of which were based upon two teaching hospitals. These two units were institutionally-based. There was one specialty based unit made up of the district's community services. The district had three other units which were categorised as client-care based. These were responsible for managing mental illness, mental handicap, and maternity/paediatric services. The normal pattern in 1982 was that districts were formed by the division of AHAs. HD 23 (Wimbury) was, instead an amalgamation of two previous health districts.

In the second category, those health districts which had not adopted radical structures and where the authority members had been involved, was HD 12 (Dunhurst). A working group of the authority's members recommended five management units two of which, those responsible for mental illness and mental handicap services, were client-care based. Part of the mental illness services were managed in another unit based upon the district's general hospital, one of the two units which were categorised as institutionally-based. Finally there was a unit based upon the district's remaining community services. HD 12 (Dunhurst) was unusual in having a county boundary passing through its own area.

HD 6 (Heathdown) was the only district in the third category. Health districts were categorised as being more radical in their arrangements if at least half their units were based upon client-care groups. HD 6 (Heathdown) had two client-care based units and two geographically-based units, but no formal

involvement of the health authority was documented. These two geographically-based units were based upon two general hospitals in towns at either end of the district. Outside of large cities, it is unusual for health districts to have more than one large general hospital and it was part of Heathdown's particular problems that in between these two towns were almost twenty miles of countryside with no health facility apart from primary health services. Its two client-care based units were one managing mental illness and psychiatric services and another managing mental handicap services. One other feature of this district is that included within its boundaries was a hospital serving a small town which was managed by another health district in another health region. HD 6 (Heathdown), however, was still responsible for the community services and other health needs of this town's population.

In the final category, those health districts where the members appeared not to have been involved and where the structure had not been radical, was HD 7 (Milham). This district had a five unit structure which included two client-care based units, one for mental illness and one for mental handicap. Another unit was institutionally based, on a hospital serving the elderly and providing acute/general services. Then there were two specialty-based units, one a maternity services unit and the other a community unit. The maternity services unit was not a client-care based unit being only responsible for hospital-based care of patients within the general hospital. It shared its unit administrator and all support and medical staff with the general/elderly unit.

Analysing the survey evidence

Once the interviews for the survey had been conducted, the evidence was assembled into a form ready for presentation in Chapters Five and Six. This necessitated making a selection from many hours of talk. The selection was made according to which statements constituted evidence to demonstrate the progress of the reorganisation in the districts. The emphasis was, therefore, on illustrating power, influence, and interests.

In responding to a question, the interviewee might have expressed an opinion and backed it up with evidence to support what they thought. This was often factual, or else was an opinion of a past event presented as factual. In any event, the evidence (factual or otherwise) selected to illustrate or justify the opinion held, had to be treated as just that - selected evidence. By and large, Chapters Five and Six deal with opinion. Some responses reported were about certain events or things which can reasonably be regarded as factual. In reporting the results of the survey, these were distinguished from the majority of responses which were statements expressing opinions, interpretations of events, or inferred causes.

Before writing Chapters Five and Six, an account was written for each of the four districts. These separate histories were written into an intervening account (not presented as part of this thesis) which concentrated on the differences between each of the districts. This made it possible to see what their individual reorganisation histories had in common and to see in which ways they differed. It became possible to contrast and compare them.

Chapters Five and Six were then written as a result of being able to see what occurred to and within each of the districts. These chapters, as well as the intervening account, were written by combining the facts presented and the opinions presented as factual where, and only where, these were commonly and consistently expressed. Facts over which there appeared to be some room for dispute were not included except in as much as they were recorded as different accounts of events. Different interpretations of the same events were also included but on the same basis. So, the responses given by each interviewee were subject to scepticism requiring corroboration. Even then, they could only be accepted as the truth as it was known to the respondents. The question asked was "Will the statement stand up under challenge?" In the absence of contrary evidence or contrary opinion, some statements can be accepted - with a high degree of probability - as being factual. However, acceptence alone does not constitute a fact. As King (1982, p266) so succinctly put it, "Statements, made with the best of good intentions, vary in their accuracy, the meaning with which we endow them, and the degree to which we can accept them as facts." The process being described here is no more than that of giving critical attention to the validity of statements: drawing a distinction between statements and facts throughout the study.

Chapters Five and Six are presented as a result of combining the things which were common to all four districts in the intervening account. Differences from the common pattern are noted and described. The chapters show how each of the health districts surveyed were able to implement the delegation and devolution of

decision-making that the government had said was the intention of the reorganisation. They also show the extent to which delegation and devolution were undermined by measures taken by central government after April 1982. The extent to which the medical and nursing professions were able to take an active part in the management of the districts is also described and an account given as to why this varied. Quotations were selected from the interviews to illustrate the main points of the analysis. They illustrate what their histories had in common and in which ways they differed. Generally they typify the responses obtained. Where the response was an unusual one, this is stated.

Lastly, Chapter Seven was written as a conclusion to the study. It draws together the analysis of the 1982 NHS reorganisation and examines it in the light of the theoretical discussion of power in Chapters One and Two.

Chapter Four
Reorganisation: the formal evidence

Introduction: the SE Thames and SW Thames health regions

The 1982 reorganisation was effected by a series of government circulars. Chief among these were HC(80)8, DA(81)7, DA(81)2, DA(81)1, and HC(82)1 (DHSS, 1980, 1981, 1981a, 1981b, and 1982). These required districts to take decisions on such matters as accountability, personnel, and professional advisory machinery. This chapter examines the recorded evidence of decisions on unit management structures made formally by District Health Authorities (DHAs) in the South East Thames and South West Thames health regions in 1982. Part of the intention of writing this chapter was to set the scene for the remainder of the investigation but, as will be seen, the visible evidence on which it focusses was open to more than one interpretation. The evidence has been extracted from the minutes and agenda papers, as well as other sundry documents, and analysed. In some cases documentation was obtained that had been produced by the shadow authorities, set up before 1st April 1982.

In describing this formal evidence, conventions are adopted for the sake of brevity. The use of "DHA" is confined to the District Health Authority in its formal sense, and not to any of its officers and staff. When the whole health district is referred to, it is referred to as, say, HD 1.

In looking at these documents the focus is on the decisions taken, particularly at the officer and member level. Unit structures were an organisational issue and one where the bureaucracy's legitimacy of action was likely to be well recognised. Nevertheless, there was some evidence of activity by doctors and

also by nurses, particularly those in the community services, to attempt to influence outcomes.

The formal decision processes

Circular HC(80)8, in bringing about the establishment of units of management, also made it clear how they were to be defined. The government wanted units established so that decision-making would be carried out more locally and the delegation of decision-making to a local level was an essential part of the goverment's strategy. The documentary evidence examined, in some cases, makes it clear how this was done. Although there appears to have been no debate on this, the minutes and papers of some health districts describe the terms of reference of units and the extent to which decision making was to be delegated. Five DHAs (DHAs 8, 18, 20, 22, and 28) were provided with these details as part of their agenda papers. In six districts (HDs 5, 6, 7, 9, 17, and 28) the issue of professional representation in the new structures was also discussed, although DHA 17 only considered the medical advisory machinery.

Circular HC(80)8, in paragraphs 27 and 32, stated that "either in shadow or substantive form", it will be for DHAs to decide what appointments to make and to determine arrangements for accountability. DHAs were accountable to their RHAs in certain respects only. The role of the RHA was set out in HN(81)34 (DHSS, 1981c), and was limited to;

"(a) ensuring that the DHAs had formulated their management structures and arrangements in accord with the principles of HC(80)8, ie; that each DHA shall appoint a DMT, that each DHA is divided up into units which should be smaller, in the main, than existing sectors, and that decision making be delegated to units through ensuring that accountability of non-clinical support staff was to the unit administrator wherever possible, and that there should be a senior member or senior members of the medical staff to whom the administrator and director of nursing services can relate.

(b) ensuring that management costs were within limits prescribed.

(c) ensuring that the gradings proposed are appropriate to the duties and responsibilities and not out of line with existing grading standards."

Paragraphs (b) and (c), dealing with management cost limits and gradings, had significant effects on the determination of unit structures which will be discussed later. The DHAs were constrained by RHA timetables and the other RHA requirements, in addition to those of HC(80)8, but the instances of a typical procedure being followed were outnumbered by exceptions. In most cases the decisions on management unit structures and management arrangements were agreed by the DHA two or three months after 1st April 1982, the date when the reorganisation took effect.

The unit structures issue was considered more visibly by some DHAs than by others. Some DHAs were more open to the possibility of participation than others. Five DHAs (11, 13, 15, 22, and 24) were particularly open in this respect, although the visibility was a matter of degree. In these DHAs there was evident consideration of a number of options among a wide variety of interested parties, and this was sometimes extended to include outside bodies such as the Community Health Council (CHC). DHA 22, for example, considered a document which, although presented by its DMT, listed eleven options including a few which were proposed by other interests such as the Medical Executive Committee. At the other extreme, there were seven DHAs, as noted earlier, in which the unit structures issue was considered partly "in confidence". This was done ostensibly to protect members of staff at the time of reorganisation but in two DHAs (4 and 17) the minutes remained confidential subsequent to the 1982 reorganisation.

In other DHAs, members do not appear to have considered the issues at all, although all the minutes and papers were made available and examined. For example, in DHA 5 the reorganisation was not mentioned in the minutes or agenda papers. Although the minutes of DHA 5's first meeting recorded the approval of the minutes of the shadow health authority meetings and it was noted that;

> "these particular minutes included the approval of Standing Orders and Standing Financial Instructions and the disposal of the B..... Children's Unit and W..... Hospital sites."

No mention was made of the organisation of the new district.

Member involvement in most DHAs was limited, but to a lesser degree. The issues of reorganisation were presented in a selective fashion, for example, in DHA 14 where the minutes of a meeting in April 1982 record;

> "...It was pointed out that the structures had so far been formulated piecemeal, and that the DMT [District Management Team] would soon be discussing the overall position with a view to the creation of a fully comprehensive document for submission to the RHA. The tight timetable was appreciated and consultation via the District Joint Staff Consultative Committee was currently being organised."

The next meeting of DHA 14 considered a paper on management arrangements as well as a paper entitled "Philosophy of Management Arrangements". This latter paper dealt with accountability, delegation and grades. Its subheadings included such topics as the district's dental, pharmacy, chiropody, speech therapy, catering and domestic arrangements, but did not deal with the basis on which the proposed units of management were to be structured.

Member involvement may have been limited by the dominant effect of previous decisions. Thus, district reorganisations or rationalisations, already set in train, may have been used to pre-empt the proposed management structure decision. Although a few DHAs were asked, by their DMT to use previous decisions as criteria, in determining structures, two districts exemplify this

particularly well (HDs 3 and 28) although both later found themselves with some room for further manoeuvre. HD 3, for example, had begun a rationalisation of all its services because a new 500-bed district general hospital was being built. Consequently it had several small hospitals to close or whose use was to be changed. One hospital was to be closed, refurbished and then re-opened. Surgical work was to be centralised. These moves so dominated this authority and its officers' efforts at the time, that the 1982 reorganisation may have been seen as of secondary importance. Hence, the DHA chose to devote very little time to the issues formally. Even so, there was some formal consideration given to part of the reorganisation issue. The DHA was presented with a paper by its DMT which made firm proposals and in which it was stated that "...the care-group philosophy is more tenable." However, the DHA was asked to consider options for the division of acute services into one or two units of management. In the other example (HD 28) the DMT initially proposed a structure that incorporated decisions about structure that had been taken two years earlier as a result of the Nodder inquiry (DHSS, 1980a). However, member involvement in this DHA, as will be seen later, was not to remain limited in this way.

The documentation examined suggests that both officers and authority members began to formulate proposals long before 1st April 1982. In HD 18 the District and Senior Administrator put forward unit structure proposals as early as June 1981. This was exceptional because it was generally only toward the end of 1981 and beginning of 1982 that districts gave reorganisaton any serious consideration. HD 18 was also exceptional in that it was

one of only two health districts where there is any evidence of senior administrators proposing unit structures without assistance from the rest of the DMT. It was rare for initial proposals to be made by individual officers because they were usually made in the form of a paper from the full DMT or from a group of members to the health authority.

In three districts (HDs 7, 17, and 22) preliminary work had been done by the Area Management Team of the Area Health Authority (AHA) or the DMT of the health district that preceded the restructuring. Thus in HD 7, the shadow authority's minutes of February 1982 record that;

> "Mr R...[the DA] reported that the "old" DMT had already looked into the question of future management arrangements. but as Mr M...[the District Nursing Officer] had not been a party to these discussions, it would be necessary for the new team to give consideration to the matter."

In HD 21 the shadow authority met and discussed the setting up of units in February 1982. The DMT were subsequently in agreement with its shadow authority and went ahead with proposals that conformed to the shadow authority's suggestions.

In some districts member involvement was high. Members in five authorities (DHAs 8, 15, 18, 23, and 24) were able to attend seminars for a day to consider the issues. In other districts a special DHA meeting was held to consider the issue alone (HDs 13, 22, and 27) and in HD 28 there was an informal meeting of the authority members. In a minority of cases the initial proposals

came from a working group of authority members, sometimes working with the DMT. These member working groups went under such various titles as: "Ad Hoc Sub-Committee", "Finance and Establishment Ad Hoc Sub-Committee", or "Staffing Structure Panel". Ten DHAs (8, 10, 12, 13, 17, 18, 19, 20, 24, and 27) had such a working group of members. However the role that these groups took varied considerably. In HD 12 the authority requested one of its sub-committees to take on the responsibility to propose unit structures and this it did following a meeting with the DMT. This sub-commitee was then later asked to finalise and agree on the authority's behalf the formal submission to be sent to the RHA. Such working groups, by their nature, involved some members while excluding others. Only in HD 12 did it appear that the members working group had a deciding influence and responsibility for initiating the unit structures decided. In other HDs, where the members' working groups were involved to a lesser degree, the DHAs did not have a determining influence on the unit structure. DHA 8's members did not formally and openly consider the proposals that the DMT had made until a members panel was asked to examine a second version of the management structures as late as 1st September 1982, while the RHA had considered the senior posts before 1st June.

Obviously member involvement reduced with the passage of time and with the need to consider other issues. This was particularly noticeable in those cases where the authority members' involvement had been high at first. Take DHA 24 again as an illustration. All members had attended a seminar on the reorganisation early on and where later, a working group of members had examined the DMT's

options to establish the validity of each of the structures proposed. Member involvement was much more limited by the middle of 1982 when the chairperson was able to reinstate headquarters staff posts that the authority had accepted should be deleted after the chairperson had discussed with the RHA the formula by which managements costs were calculated.

So, in general, it was the DMT that took on the major part of the task of proposing structures, and the authority members' role was restricted. The following three examples demonstrate how limited member involvement sometimes was.

a) The members of DHA 16 agreed, in March 1982, to a suggestion from their chairperson that the DMT produce a consultative paper which would be approved by him on their behalf. Comments would then be available for consideration by the health authority at its April meeting.

b) DHA 6 even agreed to allow its chairperson to accept alterations, to its adopted structure were they to be suggested by the Regional Advisor, without reference back to the full authority.

c) It has already been mentioned that the issue of reorganisation failed to appear in the minutes of DHA 5. The DMT did, however, make a monthly report to its DHA at which the issue might have been considered although not as part of the agenda. The members expressed, at their May 1982 meeting, that "future reports in greater depth would be helpful to members". Despite this the minutes of the following meeting recorded the

agreement of members to;

> "An effort had been made to respond to the request for a report in greater depth but members were asked to note that the report covered mainly matters of general interest; matters of major importance would appear as substantive items on the Authority's main agenda."

Generally there was considerable pressure to minimise debate because agreement was necessary within a short time span so that the RHA would agree to appointments being made. Timetables were set and structures agreed subject to alterations that might be necessary as a result of consultation with staff, or amendments necessary as a condition of RHA approval. According to one district chairperson, the South West Thames RHA was two months behind other RHAs in approving second-in-line posts. Districts in this region considered reorganisation more often "in committee", and DMTs were more reluctant to allow their members to consider options, than in the districts of the other region studied.

In four districts (HDs 8, 9, 12, and 26) the policies were agreed "for consultation" purposes but submitted to the RHA before the consultation with local or internal interests had begun. So, in HD 8, where the RHA had required the consultation document to be submitted before 1st June 1982, and where the RHA had approved the senior posts by that date, the members appear to have become involved with the consultation document as late as September 1982, and the "Nursing Structures" consultation document was actually dated January 1983. The necessity to save time, together with the regionally determined deadlines and timetables, may have been the

reason that districts submitted their proposals to their RHAs before the consultation process began. Accordingly, the authority in HD 12 agreed at its meeting on 13th May 1982, that its proposals for units of management structures would be agreed in principle "for consultation and indication to the RHA", and that at its meeting in June it would engage in "consideration of comments received from consultation and decision on management structures and agreed submission to RHA". In the South West Thames health region, it was comparatively rare for consultation with union or medical representatives or with outside recognised interests to take place as part of the process of devising policy proposals. Consultation documents tended to be submitted to the RHA at the same time as they were submitted to the "legitimate interests" and consideration of the comments of these interests were considered after the RHA had received and commented upon the document. In the South East Thames health region, this position was reversed. SETRHA required DHAs to submit proposals according to a standard format, known as a "surveillance document", which specifically demanded that the DHA describe the consultation that had taken place in reaching the proposals. Thus DHA 24 approved its proposals, after consultation with the District Joint Staffs Consultative Committee before they were submitted to SETRHA.

The policy documents

Nine of the papers proposing management structures began with an introduction to circular HC(80)8 and the decisions that were required in it, along with some brief description of the

philosophy of approach in both the circular and the earlier consultative document "Patients first" (HDs 7, 13, 18, 19, 20, 22, 24, 27, and 28). Sometimes, though, the content or substance of these guidelines was given verbally and is recorded in the DHA's minutes.

Sometimes additional or alternative principles were included that related to "good management". A paper presented to DHA 15, for example, under the heading "Principles of management structures" stated;

> "... the main thrust of government policy is for a simplified, less costly structure for the NHS with emphasis on 'local' units of management. The DMT in reflecting this general approach considers the following principles to be important:-
>
> i) Change should not occur merely for the sake of change; rather the opportunity should be taken for logical rationalisation where appropriate;
>
> ii) Structures should be devised showing clear lines of management accountability for such matters as budget control, discipline and communications;
>
> iii) Responsibility and matching authority for decision making should be devolved to the lowest appropriate level in the organisation;
>
> iv) Structures should be as simple as possible and capable of easy understanding by staff and others;

v) The decision taking/implementation process should be speedy;

vi) Structures should be so designed as to allow the setting of objectives and standards capable of easy and regular review and measurement;

vii) The nursing and administrative management arrangements should be matched as closely as possible;

viii) All functions should be organisationally related to one of the DMT officers, with no direct access to the Authority."

In some DHAs, the paper also made reference to principles that arose from local conditions. For example, a paper put by DHA 17 to its RHA stated;

"In summary there are six major features of the District which have significant influence on the Authority's organisation:"

Three of these were

"i) the need to plan with two local authorities, who themselves each have to plan with two Health Authorities.

ii) the nature of the resident population, particularly immigrants and unemployed, many of whom are living in run down inner city accommodation."

and

"v) a number of large additional training facilities in addition to the responsibilities connected with undergraduate medical and dental training."

Another example is that of DHA 22 which was presented with a paper by its DMT that referred to problems of geography:

> "The hospital service in (the district) are in a patchwork of small hospitals and with a considerable geographic spread. With ten such hospitals it becomes difficult for (the district) to arrive easily at a straightforward pattern of management."

The justifications used for recommendations

The use of unit basis as a justification

When options were presented to health authorities, they tended to be in the form of specific proposals for units, and only rarely did the choice between different bases get discussed without reference to district services or institutions.

Nine DHAs (10, 13, 18, 20, 22, 24, 25, 26, and 28) were presented with a number of options. However, it should be noted that, in HD 26 the DHA was first presented with a discussion document which included firm proposals - although this left the organisation of its community services undecided - and options were only produced as the result of a DHA request. Additionally, DHA 3 was presented with a paper that proposed a unit structure with options on how its acute services were to be organised.

Where options were presented to the DHA, recommendations were made in the original paper in five of the nine districts (HDs 13, 18, 24, 25, and 28). The recommended option was adopted in three of the five. The exceptions were HDs 13 and 28. In HD 13 an

amendment to the recommended option was proposed by the District Administrator and later accepted by the authority. In HD 28 the authority requested the DMT to reconsider dividing the management structure by a different basis.

In five (HDs 13, 18, 24, 25, and 27) of the nine districts where options were presented for the DHA to consider, the the list of options also included a summary of the advantages and disadvantages of each of the proposed options. The list provided for DHA 27 did not initially contain a recommendation, while the remainder of the option papers stated a preference for one of the listed options. In HD 13, for instance, a preference was stated initially by the working party of the authority in presenting a policy paper that listed six options with what they saw as the advantages and disadvantages of each. Option A (not adopted) was for keeping things as they were. The existing sectors were to be named Unit A (the West Sector) and Unit B (the East Sector) and each was to encompass all hospitals in each geographic unit. Six advantages were listed including some that related to some central concerns of management, such as;

"3) The size of the units would prove a worthwhile management task for the unit officers and merit a reasonable grade for them.

4) The District Administrator's and District Nursing Officer's span of control would be minimised."

However they also included advantages that related to the ways that professional staff would work, such as;

"5) The inclusion of community services within each unit of management would contribute to the two branches of the service operating as one rather than creating a distinction (see disadvantage 3 below)."

Among the disadvantages to option A were listed;

"2) The size of the units may make it difficult for the unit officers to be really au fait with the community services, particularly for those services which are at present run by the Community Health Branch.

3) Dividing the management of community services would be less efficient."

No recommendation was made in this policy paper, although one emerged at a meeting of the shadow health authority's working party attended by the DMT and three members. The working party chose option C based on two general units plus one community services unit. The advantages of option C included;

"1) The sizes of the two general units and the community unit would provide a worthwhile management task and merit reasonable gradings.

2) A reasonable span of control for each unit officer.

3) The establishment of a community unit would ensure that they have a separate voice."

The disadvantages included;

"1) Management costs might be higher than option A.

2) It might overemphasise the distinctions between hospital and community services.

3) Agency service arrangements for support services would have to be made in respect of the community services unit.

4) The scattered nature of the community unit and nursing staff would cause problems of communication, although these would possibly be minimal."

Both the DA and a doctor proposed amendments to option C to "safeguard" priority groups. These were to be treated as separate units of management as far as nursing and medical services were concerned, to have separate nursing and medical budgets, and to have direct reference to the DMT. The DA's proposed "safeguards" had previously been rejected by the DMT, but they were adopted at the shadow DHA's meeting of 12th February 1982 and extended so that they applied also to options A and B. So, instead of the original six options proposed, the DHA had nine options to select from when it met later and decided to chose option C with "safeguards".

In this example, as in most cases where options were presented, no explicit prior consideration appears to have been given to the basis to be used for dividing the district into units; that is, whether units should be based upon clinical specialty, geography, institutions, or client-care groups. The advantages and the disadvantages of unit bases were implicit in the paper's treatment of the advantages and disadvantages of the individual options proposed. Where options were presented to DHAs it is only in HDs 18 and 24 that there was any previous consideration of the merits or disadvantages of the unit bases in principle.

Explicit prior consideration of the bases to be adopted was usually followed by a firm proposal and not followed by a consideration of options. Prior consideration of the possible unit basis that might be adopted was followed by a firm proposal in five districts (HDs 10, 15, 20, 26, and 27). In HD 10, for example, in the introduction to a DMT paper, it was stated that;

> "In considering these options [which also included the DMT's consideration of the 'correct balance between devolving decision making and providing realistic management tasks'], attention has also been paid to the 'institutional' versus the 'functional' approach. It is felt that the functional approach, whereby the units of management are based on client-care groups without regard to institutions, does not enable responsibility of local managers to be clearly identified: the units proposed represent a balance between a desire to group client-care services together, whilst having clearly identified officers for each site."

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Nine of the policy documents presented to DHAs contained options, and fifteen policy documents presented to DHAs contained firm proposals (DHAs 1, 6, 7, 8, 9, 10, 11, 15, 16, 18, 20, 21, 23, 26, and 27). Unlike those DHAs listed earlier (DHA 10, 15, 20, 26, and 27) they did this without a consideration of the principles of unit bases. In HD 7, for example, no options were presented and no justification for the proposal was made by the DMT in its paper. The DHA was presented with a paper entitled "Proposed structure and management arrangements" in May 1982. *It had no* introduction, but began with a description of each of the five units proposed; the population served, their premises and services, the number of posts, and their budget. It then stated;

> "NOTE:
>
> The proposed units of management have been the subject of full consultation and represent the final proposals of the authority."

There then followed several pages of organisation charts. The DHA had had a formal opportunity to discuss the issue earlier, but there is no record in earlier minutes of the issue being explained to members. Structure and management were on the agenda of the previous meeting in April. The minute, in full, records that;

> "[The DA] reported that detailed nursing structures had still not been formulated owing to delays in gradings negotiations at a national level. Nevertheless the proposed management structures would be presented to the District Health Authority at its May meeting, and would then be presented formally to the

July meeting of the Regional Health Authority for approval."

In January 1982 the shadow authority discussed the draft document "Structure and management" at a special meeting and the paper was amended in respect of the responsibilities of unit managers and the medical and other professional involvement in the District Planning Team. At the shadow authority's normal January meeting, the District Administrator, in introducing the draft paper, pointed out that;

"...there were in fact five separate exercises involved on the transfer of staff at reorganisation."

The fifth of these was "Units of management". After initial discussion, the nature of which was not recorded, the meeting closed and further discussion was deferred to the special meeting later in the month.

The issue of units of management structure was not always treated separately from the wider issues of management arrangements. For HD 7 was not alone in having units of management structures treated in this way, there were five others (HDs 9, 14, 16, 19, and 23). In the case of HD 19 the unit structures issue was considered by a "Staffing Structure Panel", all the issues were considered under agenda headings of "District Staffing Structure", and there was no consideration given to either unit structures or the basis of units. These were taken as given and attention was devoted to the posts within the structure. In this way, the issue of unit structures was subsumed under consideration of district management arrangements such as the organisation of the works or

finance departments and the consideration of the appropriate gradings of staff.

DMTs and DHAs preferred not to argue the case for their recommended options or proposals by direct reference to the merits or otherwise, of the clinical specialty, geographical, institutional, or functional bases of units.

The use of management costs as a justification

At the same time as the reorganisation of the NHS, health districts had to deal with the "management costs exercise" announced in paragraph 34 of HC(80)8. However costs were not usually used explicitly as a justification although costs were significant in many of the justifications used. They could be significant in one of two ways. First, they could determine the number and type of units. HD 22, for example, is a small district and the resultant small amount of money for administration had a bearing on the units proposed. In a report, entitled "Management arrangements", by the DHA Working Group, the first conclusion stated is;

> "The Working Party is of the opinion that the proposed structures will provide effective management which will meet the requirements for the Health Authority to deliver a standard of health care consistent with the resources available."

The other way in which costs could be significant was in the tasks that units were expected to undertake. To use HD 22's DHA Working Group report again as an example, one of the conclusions reached was;

> "The transfer of services from District to Unit will make a good contribution to management cost reduction. The simplification of a number of structures and slimming down of some services will make a significant influence on cost."

The use of management tasks as a justification

It is not entirely possible to distinguish between the use of management costs and management tasks as justifications for the proposed structures. Certain management tasks were exempted and so there was considerable financial benefit if tasks that had previously been undertaken at district HQ level, or at the level of the old AHA, could be undertaken at lower levels in future. DHAs frequently considered whether personnel or works functions could be delegated down to unit level. So, in HD 23, for example, the surveillance document submitted to the RHA stated among its explanation of the factors the authority had considered necessary, the principles the authority considered should be the basis for the relevant management structures. Among the principles listed was;

"c) certain services should be provided on a centralised basis to ensure uniformity and a comprehensive district-wide approach, eg personnel, planning and information."

Only one proposal specifically referred to the notion of "levels of work or work strata" as promulgated by Elliott Jacques and members of the Brunel Health Services Organisation Research Unit (Jaques 1978). This occurred in HD 25, also a relatively small district, and the proposal made by its DMT went so far as to include a description of the Brunel work strata model. The paper then stated;

"With this approach important parameters are set for the new units, whose officers would need to be involved in producing comprehensive plans and budget proposals for their spheres of authority as well as managing them c a day-to-day basis."

If a small health districts was to ensure that it was able to attract management of high calibre, then it found itself having to provide large enough management tasks for the unit administrators to warrant high salaries. The unit structures were, therefore, framed to some extent by this requirement. The DMT in HD 21, in supporting the nursing structure proposed by the District Nursing Officer, stated;

"It is confirmed also that medical and finance opinion within the DMT supports the joint proposals (the unit structures together with the nursing structure) now submitted, in particular the forming of units of sufficient size to enable the highest possible salary grades to be offered to administrators

and directors of nursing services respectively. However, it is stressed that in so doing particular attention must be paid to ensuring the provision of managerial staff of suitable calibre in support of the top posts for proper control of these large units within the devolved responsibilities and financial constraints, and all that this implies."

The management task envisaged for the DMT was used as a criterion, particularly in the larger districts, where there was a concern for the span of control. In HD 24, for example, the span of control was one of the considerations listed among the advantages and disadvantages of having three, four, or five units. In HD 20, a document entitled "Management Structures" and dated March 1982 included a section entitled "Critera for the revised management structure" which, in addition to including span of control also included;

"(b) The unit should be large enough in terms of numbers of staff, resources and management complexity to warrant the appointment of a full-time administrator and nurse (but see HN(81)34 paragraph 3 (ii))."

and

"(e) The unit should not be so large that the administration and nursing require a complicated sub-structure to be established."

The use of organisational effort as a justification

Another consideration used as a justification, and one that DMTs might have been expected to favour, is that of the organisational effort involved in the change itself. In HD 28, a minimum change strategy was initially adopted by the DMT, although subsequently overruled by the authority.

Nevertheless, most DMT's appear to have regarded the 1982 reorganisation as an opportunity to alter previous arrangements. The initial paper of DMT 25, for example, stated;

> "We consider the present structure which is staff orientated and has a fundamental centralist approach to the administration of the District, resulting in a "headquarters" overview of planning decisions and recommendations, and a similar control of operational service activities, and a number of variations on this a·proach. We went on to consider a patient orientated approach based on the delivery of care to client groups."

Later, after describing option 1, based on HD 25's previous administrative structure, the paper stated;

> "A case could therefore be made for either retaining it in its present form or with minor variations which would be consistent with a philosophy of minimising turbulence within the organisation.
>
> However, the DMT consider that the present structure is not sufficiently sensitive to change in the patterns of health and social care in the detailed collaborative service requirements

of mothers, children, elderly and mentally ill and mentally and physically handicapped etc.- that it perpetuates the distinction between hospital and community care, and that it is impossible for the medical component of unit management, as proposed in HC(80)8 to be organised."

The paper then went on to a consideration of other options, of which the last was preferred. The last was a radical departure from previous arrangements, although it was eventually decided to be unworkable, being one unit for acute or single incidence treatment, and one other unit for defined groups of the population requiring continuing and co-ordinative treatment.

The justifications favoured by members and by officers

When justifications or policy documents were put forward by member working groups, rather than by the officers, there was no discernible difference in either the way they were arranged or in their substance. They were just as likely to contain sections on functional management or the responsibilities of managers, and just as likely to concern themselves with individual posts. Of those member working groups, of which there were six that were responsible for making unit structure proposals, only the group in HD 20 considered options. The other five working groups had preferred to make firm proposals. Although unit basis was just as rarely used explicitly as a justification, it is apparent that client-care groups were a favoured basis in these proposals. In HD 27, for example, the Restructuring Panel of Members considered that;

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> "the existing division into sectors has created valid management units and should be changed only for sound practical reasons, ..."

Nevertheless it made several recommendations that would have altered arrangements, one of which was justified thus;

> "The present association of small units does not reflect any specific service policy. We recommend that links based on care group integration should be fostered, whenever possible, particularly for the elderly."

The preference of authority members for client-care groups to be used as a basis for units was reflected in several proposals. Nowhere was there expressed a preference for other bases, except that reference was frequently made to efficiency and practical management concerns that might make care-groups an unacceptable basis. So there was an implicit recognition of the value of other unit bases. This preference among authority members, for client-care groups as a basis, was also apparent where there was no member working group, as will be seen in a later section on the opposition to proposals.

Another form of preference was generally expressed by DMTs in those districts which were responsible for managing teaching hospitals. In order to preserve the anonymity of these districts it is not always possible to use the numbering system adopted here in presenting examples. There are four such districts in the regions described here, and in each of them the DMT put forward a paper proposing a minimum of change. In each of these, except

HD 28, the DHA accepted the DMT's recommendation. DMT 23 recommended a structure that preserved the strength of its teaching hospital by incorporating it in an institutionally based unit, while client-care based nursing units were established throughout the rest of the district.

Generally those DMTs in teaching districts made proposals aimed at preserving the unity, or the political strength, of their teaching institutions, by the recommendation of institutionally based units across the district. For example, one of the consultation papers produced by a teaching district's DMT stated that;

> "4.3 Consideration has been given to the establishment of units, following a care group pattern, but it is felt that at this stage such a radical redistribution of the management arrangements would be unnecessarily traumatic and not provide the most effective means of managing the service. It is, however, clearly necessary to establish new units in accordance with the principles laid down in HC(80)8."

None of these proposals, however, made statements that directly related the preference for institutionally based units to the teaching responsibilities of the district. They do not suggest why teaching districts rather than other districts found it desirable to adopt a minimum change approach, or why it was that teaching districts favoured an institutional approach to their unit management. Perhaps the phrase, used above, "unnecessarily traumatic", conceals unspoken reasons.

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Evidence of conflict

Some form of conflict over the issue of unit structures was apparent in the majority of the DHAs whose minutes and agenda papers were examined. In cases where no conflict was evident, it was often the case that the information available was scanty, rather than there being evidence of no conflict. The presentation of a proposal for unit structures placed those within each authority in what Finer (1974, p7) calls a "predicament". The proposed structure could either have been accepted or some other course taken, so a decision became necessary. Two features must coexist, if a predicament is to be distinguished as political (Finer, page 8). First, a given set of persons must require a common policy, and secondly the members of these sets of persons must advocate, for this common status, policies which are mutually exclusive. Non-acceptance of the proposed policy, while not advocating an alternative policy would also have resulted in a political predicament simply because to choose not to act, not to agree to the proposal, constituted a mutually exclusive alternative.

Conflict existed because of the incompatability of two or more proposed courses of action or policies, and HC(80)8 ensured that there was a need to adopt a common policy.

Alternative policies were not always proposed, and objections not always made apparent. The absence of a political predicament does not mean an absence of power or political action, as was shown earlier in Chapter One, and this position will be discussed later. Political predicaments arose, however, when health authorities

were given options to consider. This happened in two ways;

a) The DHA was presented with a policy paper that incorporated options. Sometimes papers contained optional arrangements for part of the service only, such as the acute services or the community services. Sometimes one of the options presented in such a policy paper was recommended. In others no option was recommended or favoured at first.

b) Alternatives were suggested by other than the initial proposer. Alternatives were proposed to either the proposed policy as a whole or to some part of it.

In cases where objections were made to a proposed policy of a fundamental nature, such that it was thought unworkable or unacceptable by the objector, they have been considered as a sub-set of division (b), even where no alternative proposal was made. This is because the distinction that would be used in order for it to merit a further category is that of the degree of determination to prevent the acceptance of a proposal rather than the source of the alternative.

Opposition to proposals

Once a health authority adopted a proposed unit structure, it was usual for its DMT to be asked to produce a "consultation" document to be considered by professional and staff interests. This was invariably based upon the initial policy document, if there was one, with amendments arising from the DHA's consideration.

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Opposition could come in two major forms. Either the opponent was against the structure proposed in its fundamentals, or the opposition was, while generally supportive of the proposed policy, in favour of an amendment.

Health authorities themselves could object to the policy as proposed and their objections took both forms distinguished above. Objection to the proposal in its fundamentals, by the authority itself, occurred in HDs 13, 26, and 28, although, as will be seen, the opposition by DHA 26 was fairly weak.

The events in HD 13 have already been described. In HD 28 the authority members took a much stronger role. The authority considered a paper prepared by its officers which set out three options for division of the district into units of management. One of these was based upon institutions and client-care groups, the existing sectors, and was recommended because;

> "It provides a pattern which would be reasonably well balanced in terms of workload and extent of responsibilities for senior staff at unit level. Special responsibility for the development of priority care services can be attached to senior staff whose working time need not be overwhelmed by the requirements of acute medical services."

The same paper had, before this statement, stated, under the heading of "General principles for creation of units of management", that;

> "There should be no change unless they are likely to be of substantial benefit for the management of services."

Having initally opted for a policy of minimum change, and then, having recommended a division into units that very closely followed the existing pattern of sectors, this DMT was the only one forced into a re-think by its authority members. The minutes record the DA saying that the "preferred administrative option was intended to be a mix of geographic and service responsibilities". The same minutes record the chairperson saying;

> "it did not appear to be possible to take the discussion further without more advice from officers, on the way in which the management of services to patients would cut across the management of sites, and/or the responsibilities of unit managers".

The introduction to the next set of proposals for units of management stated;

> "The Authority clearly wished to see the District move toward a care-group management structure. The model described is designed to accommodate this policy whilst also conforming to some basic management principles, and to our present ability to fix budgets."

This health district was one of a small number where the care-group basis was adopted throughout the eventual structure.

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In HD 26 the authority members' objection to the DMT's proposal concerned the fundamental structural basis but was not fought for as strongly. The minutes of a meeting in March 1982 record that the management team;

> "considered there was broad agreement that the unit structure should be on a geographic basis, possibly including a community services unit."

However, the minutes record that the authority agreed that;

> "a) the DMT should prepare a management structure based broadly on geographic units;
>
> b) options showing units for community services and geriatrics should also be prepared"

Eventually the structure proposed did indeed incorporate a unit for the district's community services.

Health authorities also opposed proposals by amending them significantly without objecting to their fundamentals. Thus in HD 14 the authority amended its DMT's proposal so that mental health services were in the same unit as the district's community services.

Visible opposition to policies also came from other actors and interests than authority members. There were DHAs where alternatives were put forward by organisations or individuals outside the HDs' formal structure, such as local CHCs. Th CHC commented upon the proposals considered by DHA 13, but the comments made were restricted to such things as the grading given

to the unit administrator for community services, the "dearth" of middle and lower middle management, the upgrading of the district's personnel officer, and the need to retain the district's information and planning function.

The other sources of comment were the medical or nursing professionals and the staff and union representatives within the organisation.

Objections to proposed policies as unworkable or detrimental could arise at any stage of the decision making process, as well as coming from any kind of source. These were not at all commonly expressed, but are interesting for the way they appear to have been dealt with. In HD 28, as was noted above, the DHA had forced its DMT to re-think its proposals, and the DMT had moved towards units based on care-groups. Nevertheless, at a later meeting, the minutes record the objections of a Dr A....;

> "Dr A... said that he was still unable to support a solution which did not include an identifiable community unit with its own budget and managers. He did not consider that the care group approach proposed constituted units of management as set out in Health Circular HC(80)8."

Another example of an objection, also from medical staff, was in HD 15 where the authority received, at its meeting in April 1982, a petition from staff at a small community hospital with some casualty provision against a proposal that the hospital be included in the district's community unit. The minutes record that the petition was noted.

In no case did such an objection meet with anything but dismissal, usually accompanied with some reiteration or clarification of the justification for the original proposal. In the case of HD 28 the objection was easily dismissed. The chairperson said that "members had already voted in favour of the care group approach" and that he envisaged the DHA making allocations and setting objectives for the care group units.

At a meeting of DHA 26, in May 1982, the members considered reports summarising the views of the District Medical Committee and management staff on the consultative paper. The minutes record that;

> "Comments relating to the proposed structure with regard to geriatric nursing services, works services, and the management of the midwifery services were considered. While the arguments put forward were appreciated it was decided that the need to develop effective management units, particularly in respect of budgetary control, remained a major objective for the improvement of patient services."

Such statements serve to demonstrate that the DMT both understood the argument and agreed that what was said may have the undesirable effects predicted. However, the DMT, from its own position as the officer team ultimately responsible, was able to point to arguments of its own that it thought more important. So it was the position of the DMT which made one argument carry more weight than another. The logic of an opponent's argument was rarely disputed, but the argument could still be overruled.

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In HD 24 the community nursing staff, in proposing alternative proposals for the new units of management, rejected the original plan set out by the DMT, for five units of management. The reasons given related to the concept of the primary health care team, and consequently a preference was expressed for keeping the community nursing service in one unit where it would not be managed by hospital based and hospital experienced nurses. *DHA 24* was rare, as will be seen later, in recommending no community unit, and the DMT's reply to this rejection by the community nursing staff was both detailed and lengthy. A member of the authority also put forward a paper arguing for a community unit, but the DMT's case was accepted. In its original paper the DMT stated that it had a firm recommendation to make to the authority, but before outlining the content of this recommendation, it stated;

> "it is necessary to set out other ways in which these units of management could be constructed...."

The paper included six options, the first three of which provided for a separately managed community services unit. Among the disadvantages listed for one of these options the DMT paper stated;

> "The DMT considers that there are disadvantages in establishing a separate Community Unit of Management. If such a Unit was set up, the Community Nursing Services would be seen as something apart from the hospital part of the organisation. The 1974 Reorganisation was supposedly about the integration of hospital and community services. Integration of these services cannot be

achieved with the two components being managed separately in terms of planning; budgets and day-to-day management."

Neither the DMT, nor the Community Nursing Services staff were in dispute about the way that a separate unit would function, or be seen to function. Instead the DMT regarded as positive what the Community Nursing Staff regarded as harmful. Under the DMT's recommended option, district nurses would become part of the unit for the elderly/physically handicapped. Health visitors, school nurses, and family planning nurses would become part of the unit for maternity and child health. The paper stated;

"it should be borne in mind that currently... 75% of the working life of a District Nurse is spent with the elderly; whilst the majority of the working life of a health visitor... is spent with the 0 - 5 age group."

The community nursing staff took up this issue, expressing concern that the proposals would limit their field of work to limited age groups of clients. The DMT, in its response, stated that;

"The assignment of the Health Visiting Service to the Maternal and Child Care group and the District Nursing Service to the Elderly care group will not impose a structural barrier to the care of patients of all age ranges. If this has been perceived as an imposed barrier, the DMT regret it has not made its position clear that at the operational level the present activities of District Nurses and Health Visitors in providing care to all age ranges will remain unchanged and the DMT would not wish it to change."

It is worth noting here that the criticisms made by the community nursing staff were limited by being directly related to how the structure would affect their own work, and their own particular patients. The criticism could therefore be overruled by the DMT who were able to stick with their original proposal by making an argument that related to the service as a whole, and especially to the service that particular client groups would experience. The original consideration of the issue included an argument against what the community nursing staff were to propose later, and the DMT was able to reinforce further their arguments and were able to allay publicly the fears that the nursing staff had expressed. This public and written reassurance ensured the nursing staff's compliance.

However, despite any objections that were made public, at some stage each DHA adopted a proposed structure. When this happened it became more difficult for others to participate in the decision making. Consultations with staff were carried out by the DMT and the senior officers, but responses or alternative proposals were to be made to the health authority itself, and so the result was more likely to be a compromise consisting of an amendment to the adopted policy than a radical alteration to a basic structure. Theoretically, the authority should have been in a strong position because of its veto powers but once a full policy has been devised, as was seen in HD 26 where the DMT had proposed a geographically based unit structure and where the authority felt able only to amend the structure to incorporate a community services unit, it became extremely hard for alternative policies to contend.

In cases of opposition where the opponent did not have that veto power, the likelihood of success was even lower. Once the proposal had been firmed up sufficiently for it to be ready for consultation, changes were far less likely to affect the fundamentals of the structure.

Compromises

Although the proposed bases of unit structures might be accepted in their fundamental form, unit structures could be, and often were, altered in response to challenges made to proposals. Only in two cases, those of HDs 13 and 28, was a proposal made by a DMT, altered in any fundamental way. In all other cases, the proposal was accepted, although opposition from medical professions was made forcefully.

Only one attempt was made by unions representing anciliary staff or administrative staff to alter the proposed unit structure fundamentally. This was HD 10, where the staff side attempted to introduce an additional five units, and is described further on.

Most attempts by staff side representatives to introduce change did not involve change to the basic structure. For example, in HD 6 the minutes record that a paper was tabled outlining the staff side comments on the proposed management structure. The comments range over all functions, that is, administration, finance, nursing, professional and technical staff. Twenty-six numbered comments were made which, together with the DMT's responses, filled over three sides of paper. The following

exemplify the the limited nature of these comments;

> "(a) The management structures as presented do not offer an adequate career structure.
>
> (b) Management has drawn up the management structures too quickly, more time should have been allocated for preparation.
>
> (c) Top posts have been overgraded at the expense of lower grades. A more balanced structure should have been prepared. Request that structure be reconsidered."

None of the comments made were critical of the structure's basis. The staff side representatives limited their comments to those that related to gradings and career structures.

Also, while not dwelling on the DMT's responses to each of the staff side's comments, it should be noted that the DMT recommended to the DHA that it accept them all. The minutes record that the DHA accepted the DMT's comments in full, although the DMT elaborated its position by stating that the gradings would be reviewed if the workload was to be increased by devolving the work to units. The DMT also recommended that any variation subsequently agreed by the Regional Advisor should be ratified by the chairperson of the authority.

Such ready acceptance by an authority, of the DMT's arguments, was not always the case. For example, in HD 10 the minutes of a DHA meeting in June 1982 record that;

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"The District Council (representing the staff side) and the District Medical Committee have considered the proposed 4 Units. The District Medical Committee has agreed with the proposals. The District Council has agreed the Acute and Community Units, but has put forward counter proposals for 5 other Units."

Later, the report stated;

"The DMT believes that the proposed Unit (one concerned with rehabilitation and non-acute services for the elderly, the mentally ill, and the mentally handicapped) is preferable, but recognises the importance of appropriately qualified and experienced clinical nurse specialists in each of these specialties. The DMT accepts, however, that with the development of local based services for Mentally Ill and Mentally Handicapped (a priority agreed by the DHA) that the Unit Structure will need to change at some time in the future."

So, the DMT was able to retain its structure and the basis proposed, while conceding to specific, non-fundamental points, and that it might need to review structures later on. The only challenges made that were successful were those that allowed compromise through amending the proposal in some non-essential fashion. Except when made by DHA members, challenges were only successfully made when they did not propose alteration of the basis of the unit structure. This holds true regardless of who the challenger was. Medical and nursing professionals appear in official papers to have been far more willing to attempt change in the essentials of the proposed unit structures. This greater apparent willingness may simply be because their actions are more

likely to have been documented, but it may also be that the willingness of medical and nursing professionals to attempt change was genuine, and did not arise from the greater observability of their political activities, and it may be that this willingness arose from a greater concern for the basic unit structures. As was seen above in HD 24, nursing staff proposed an amendment to a DMT proposal for four units with the addition of a unit for community services. In two other districts (HDs 21 and 25) there was also pressure from the community nursing staff. In HD 21 the minutes of a DHA meeting in April 1982 record;

> "Miss B..., - proposed management arrangements for the nursing service which was broadly in line with those previously agreed for administration. Members noted a choice of two options, both consisting of five management units. Miss B... explained that although a separate unit had been suggested for the community services, from the nursing point of view, it would be preferable to integrate the psychiatry community services with the Maternity Unit, and the community nurses for mental handicap with the Mental Handicap Unit."

Both options included community units but option 1 was adopted where the community unit did not include the psychiatry community nurses and the community nurses for the mental handicap services.

In five other districts (HDs 13, 22, 20, 26, and 27) the medical and nursing staff proposed alterations. HD 27 was one where the medical staff attempted to alter the DMT's proposals. The minutes of May 1982 record that the Group Medical Commitee discussed the document, and its representative was invited to speak at the DHA's

special meeting later in the same month. One of his points was related to the accountability of the District Physiotherapist, another related to the retention of a particular member of staff, but two related specifically to the essential unit structure of the district. After he had left the meeting, the members discussed "each adverse comment received, and noted those received in favour." They then agreed the structure as originally proposed.

In HD 22 the District Medical Executive Committee proposed two of the eleven options considered by the authority. One of these options had four units, three of which were based on hospitals and the fourth based on community services and mental handicap services. This behaviour accords with the predictions made in the literature reviewed in Chapter Two (Allen, 1981, Bussey, 1982, and Nichol, 1981). The paper by the district's second-in-line officers commented that this option ignored the psychiatric services and would have broken the existing links between two named hospitals. The second combined all hospital services in one unit with the community services in another. The officer paper commented that the first unit would make nursing management difficult, and that mental handicap management would be isolated from the general nursing management structure. Both of the options proposed by the DMT were for a division by institutional basis and were treating the community services as another of the institutions.

Despite the greater apparent willingness of medical and nursing professional staff to make proposals that challenged the fundamentals of the unit structures proposed, they appear to have

been no more successful than the other staff, represented by unions. And there is no evidence to suggest that where the alterations they proposed did not concern fundamentals, were their efforts taken more seriously. There is also no evidence to suggest that the originator of the proposal, whether DMT or DHA members working group, was significant in its successful adoption. It is simply the case that all proposals were all adopted in their fundamental form as proposed, with the noted exceptions of HDs 13 and 28.

Once the proposal was accepted by the DHA, it was capable only of being amended. No group had sufficient power to seriously threaten the adoption of the proposal in essence once it was adopted by the DHA. Although the authority usually accepted the proposal "for consultation purposes" only, once it had got this far the authority was then committed to it. Consultation appears to have happened only after the authority was commited to one basis rather than another.

Avoiding the emergence of otherwise latent conflicts

The description above shows how conflicting, mutually exclusive, policy options were brought into public discussion. The system corresponds to the means of participation and consultation that is commonly built into the working methods of democratic society. For instance Finer (1974, pp58-59), in describing the "democratic class of regime", wrote that they "rely upon the critical awareness of the population, and seek to convince them by a process of persuasion". However, the public involved in the

processes studied here was a restricted one.

There are many instances where the evidence is insufficient because documentation was not made available or was not sufficiently detailed. Nevertheless there appear to have been several strategies adopted whose purpose was to lessen conflict, while the issue was aired openly.

The first way in which this was done was by reference to the authority's prior commitments. The pattern of provision, or the organisation itself, was already in the process of being changed. Once such a shift had been set in motion, there were limits to the possibility for reasonable options. HDs 3 and 17 provide examples of this.

The second way in which this could happen was by restricting the agenda, so that the process was carried out in such a fashion that conflicting opinions were never sought seriously. The possibility for full discussion could not be said to have been encouraged in HD 7 for example, where the proposed structure was presented as a provisional document which had already been sent to the RHA containing no comment on the structure itself and where the questions raised concerned specific posts and gradings (a matter for consideration also by unions and the RHA).

Third, latent conflicts could be encouraged to remain latent by ensuring that conflicting options were not given proper consideration. The proposer of a policy could achieve this by adopting the strategy of both presenting the conflicting options and arguing against them. In so doing, possible supporters of

such conflicting options were robbed of a chance to make an effective political stand. Arguments they might have been able to use were appropriated, before they could be made effectively, and counter-arguments put against them. Authority members in DHA 18, for example, were presented with three options with advantages and disadvantes listed for each. Option 3 was recommended and there is no record of support for the other two options, nor any dispute that option 3 was the better of the three.

Lastly, conflicts could be lessened by making statements to the effect that any proposal made was not necessarily for all time, and could be subject to a review later. This strategy was used in at least three districts (HDs 1, 22, and 24), although it may have been a strategy used elsewhere but not recorded so visibly.

An assessment of the process

In summary, when constrained by a desire to consider face evidence alone, no consistent pattern emerges. This might be because the evidence was, by its nature, incomplete. Or it might be that there is a real lack of consistency. However, if any attempt is to be made at interpreting the available evidence, possibilities must be put forward that account for these inconsistencies. At this point it may be useful to sum up the events described, on the observed evidence alone. Although this will present a somewhat superficial view of the events, it enables the identification of the deficiencies in taking such a view. This will be done before going on to describe the interpretation arrived at which, among other things, demonstrates why there was this variety of processes

and also why these inconsistencies arose.

The initial account, based on the observed evidence alone, focussed upon that relationship most visible in health authority minutes and papers; the relationship between officers and members. While much appears uncontentious, this is the area where conflicts may surface. A consequence of examining this evidence is that it appears that the main areas of dispute and conflict were those between the health authority and its DMT. This is the arena where conflicts and disputes are brought out into the open, but not necessarily all of them. There is no way, using this evidence, of knowing whether that arena is the only one in which conflicts existed.

The responsibility for devising unit structures was, in all but one district (HD 12), delegated to the DHA's officer team. In seven districts (HDs 1, 3, 5, 6, 26, and 28) the delegation of this responsibility was as a result of a DHA decision, although in HD 28, as was seen earlier, the DHA subsequently rejected their officer's proposals. In the remaining cases the DMT did not wait for the responsibility to be delegated to it but behaved as though it was its responsibility to be concerned with the management structures: no decision to delegate was recorded. The opportunity for the authority members to take over the responsibility, or to influence the DMT was always available, but was not always taken up.

In tracing this issue through, for example HD 7, it is apparent that the DMT took the responsibility for formulating unit structures, for consulting with medical and other professional interests, for ensuring that the proposals had the approval of the DHA, and for ensuring the approval of the RHA. The DHA members had to be informed because their approval was being sought, but the officers were able to select those issues which they considered should be of concern to members. The issues they selected were often those of appropriate grading and administrative accountability. In discussing these issues, unit structures were dealt with also. Unit structures were approved by virtue of being incorporated into wider issues of management arrangements. The authority members were limited in what they could take a proper interest in.

Consequently, members' behavior was limited to validating the work of their officer team. Their task was not to be involved in the full detail of the decision, merely to be sure that the officers were competent, that the officers had thought out the issues, and that they had consulted with other interests and others competent to judge the proposals as workable. This initial account of the members' behaviour is consistent with studies such as that of Charnley (1983) and with the experiences described by Klein (1982). In Charnley's study, the role of members was described as exercising "the minimal influence they have", namely the peripheral influence of "stopping the worst excesses" of management and the medical profession".

What is not clear is whether the members felt this to be their role. Both Klein and Charnley suggested that members feel this to be the only role they can practically carry out. Although it may be generally true that the members' role was seen this way, members were also able to take up issues, not necessarily in the way that the officers presented them, and were then able to go ahead and influence the decision outcome. This initial account does not explain why some authority members or DHAs felt able to intervene in this way, while in the majority of districts they did not. Authority involvement, or intervention, only occurred in a minority of districts. In the majority of districts, it was the DMT that took the major role. In so doing, the DMT faced a number of hurdles that arose from an requirement, imposed by the Secretary of State in his circular, the RHA, and the organisation itself, that others be involved.

It was the nature of this involvement, as well as the variations in outcomes described in the next section, that made it necessary for the analysis to move away from the initial account which assumed that the relationship between the DMT and the DHA was the dominant one, and that the DMT attached as much significance to acceptance by the DHA as was evident in the documentation. When the focus of the analysis was shifted away from the relationship between the DHA and the DMT and towards the totality of organisational relationships, other processes could also be seen. The weaknesses of the participation and consultation processes in actually influencing decision outcomes while, at the same time, considerable efforts were being made to respresent decision taking and policy making as being the outcome, signals the need for

suspicion. Alternative explanations need to be sought.

The alternative suggested is that the processes observed were designed to prevent the expression of conflicting interests and thus, the prevention of their legitimacy. The evidence actually fits this suggested alternative quite well but depends on the (not unreasonable) assertion that the observed decision-making process was only the final part of processes which had been going on. Accordingly, some (not all) administrators, medical personnel, other staff, and most authority members attempted to arrive at outcomes in which they had some influence. If the DMT played the dynamic role, as in all but two health districts (HDs 12 and 28) they certainly did, then their efforts and desired outcomes were constrained by the efforts and assumed wishes of other actors in the organisation (albeit to varying degrees). In order justify this approach, some features of the processes of participation and consultation need to be outlined.

There was an incentive to participate because, if people made no attempt to influence a decision, upon making some objection later to working practices, they would be open to the criticism that they should have said something before, when the structures were being set up. Politically, it can be damning not to have participated. The ability to participate is constrained by the need to so at an appropriate time.

Apart from senior administrators, others had accepted rights to propose alterations, and some had the right to dismiss the proposed policy, or order a rethink, or an amendment that might radically alter the proposal. However, it was politically

important for administrators, that they originate, and be seen to originate, the structure that others have to work in. Such participation cannot, therefore, be regarded as politically desirable by the administrators. Participation and consultation would not be useful except that they legitimate their power and the policy adopted. Such rights tend to be restricted. Their power would be diminished through their inability to reduce "contingencies" or uncertainties. Even self-assured administrators would have good reasons for preventing change to policies occuring that were not to be a credit to themselves because they might well incur extra work. Devising policies is an activity that must take up a certain amount of effort, and hence some degree of commitment needs to be invested in the task.

Alternatively the DMT may have chosen to present options which served to prevent anyone else having anything worthwhile to say about them, and served to prevent others from putting forward those options that might have appeared to be more reasonable, and perhaps more importantly, that might be adopted.

The right of others to propose alterations rarely led to dismissal of their proposals without a full re-iteration, or a clarification, of the justification for the original proposal. The opponent's chance of success may differ according to their position. Both contingency theory and elitism might have predicted a gradation in the rights of other interests to intervene in the decision process. What appears to have happened is that DMTs predicted this occurence and responded in advance. One of the ways in which rights can be graded is through the

limitation of the time allowed for consideration.

There is considerable evidence to suggest that people with legitimate interests found themselves unable to react in the time made available to them. In five districts (HDs 6, 8, 9, 10, and 16) there were explicit complaints made by parties with legitimate interests, although in HD 10 this was actually expressed by the health authority itself. In HD 16, for example, the comments made by the domestic service managers include;

> "The consultative document was formally received by the domestic service managers on Friday 26th March, and our first concern is that comments are expected by 8th April, a period of only 9 working days for consideration, and reply. We consider this consultation period far too short in view of the magnitude of implications for our service - it gives us very little time to consult with our colleagues, and union representatives, and no time at all to consult with our district manager who is away on leave until 7th April, 1982."

This timetabling constraint was not the result of internal constraints in all cases but, to some exent, was caused by regional and national pressures. In this can be seen the part played by central government in ensuring that the rights of interested parties were restricted. But in many districts the DMT or chairperson hurried the timetable along. For example, in HD 16, the minutes of a meeting in March 1982 record that;

"The chairman informed members that, at a meeting of chairmen of DHAs on 25th March 1982, it would be suggested that the programme for submission of outline management structures to the RHA should be accelerated, thus allowing second-in-line appointments to be made by mid-summer. To achieve this time-scale it would be necessary for outline management structures, including second-in-line posts, to be submitted to Region by 1st May 1982. He appreciated that this would leave very little time for discussion and consultation, but he was sure that members would agree...."

Members agreed to this proposal but at their next meeting were informed that this proposal was not approved by the region's DHA chairmen for two reasons;

"i. Many districts were not in a position to meet the timetable.

ii. The staff side of the Regional Joint Staff Consultative Committee were opposed to the proposal."

Although complaints were often expressed over the lack of time for consultation, it was not always the case. In HD 7, for instance, the DMT began the consultation process on the basis of a draft paper in January while the authority was meeting in shadow form.

The initial account of the events does not explain why it was that in some districts the timetable was rushed, while in others members were allowed plenty of time and were encouraged to be involved. Once a proposal was considered for any lengthy time, then it pre-empted other proposals gaining serious consideration.

If any other proposals were seriously considered by the health authority, then the DMT could choose to state that the proposed or recommended structure could be reviewed at a later date.

There was both formal and informal consultation but, in many cases, the objective of the proposer was to keep both these to a minimum, possibly as part of a strategy for minimising the likelihood of conflict arising.

These various methods can be termed "strategies to pre-empt participation", and do not work in the democratic or pluralistic senses of participation. Nor can they be considered as genuine consultation, they serve those with power and may be termed "pre-emptive consultation". Their existence fulfils the purpose of legitimising power and policies.

These strategies were commonly carried out in a highly visible fashion (through papers presented at meetings) perhaps because the DMT's, or officer's, power to do anything at all was to some extent reputational (Wrong, 1979). If so, then, as a power strategy, it depended on the knowledge throughout the organisation that either the DMT or the officer concerned was significantly involved before in such issues, and because such previous involvement legitimised their power. This means that the visibility of such processes was an important part of decision-making, or power-wielding, in at least three ways. First, all the actors could be seen to have participated in the decision making process, and a considerable amount of organisational effort is apparent. This suggests that these efforts may be regarded as a form of organisational socialisation

which ensured that all parties knew what decisions were being reached and why. Second, they also served to reinforce the ground rules under which the organisation works. Third, they also served the, politically very functional, purpose of using those ground rules to manipulate acceptance of the changes being made. The ground rules of the organisation included a requirement that there should be the involvement of all participants but under certain conditions. Perhaps one of the most important of these was that, although the other actors recognised or legitimate rights and interests, these varied according to their position and to the issues concerned.

The rights and interests of the other parties were, therefore, graded. This gradation of rights had certain effects. The legal responsibility conferred on the DHA the greatest ability to alter the process and the outcomes.

When a DHA committed itself to carrying out this responsibility, rather than delegating it to its officers, then the DMT had no option but to back down and comply. However, this was very rare and the reasons for this are partly attributable to the necessity of delegating this task because of all the DHA's other tasks, but is also in part attributable to the way in which DMTs manipulated their authority. The DMT might have decided to work on the assumption that the tasks associated with reorganisation would be delegated, and then adopted one of several strategies in order that the issue was decided to its own satisfaction.

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The relationship between the DMT and the authority members was rather different from the relationships that DMTs had with other actors. The agreement of the DHA was essential for a DMT's preferred option to be accepted but that agreement could often be easily won. The DMT may only have been required to show to its authority evidence of having thought the issues through. It was bound to a demonstration of its competence to its DHA. To demonstrate this, DMTs had to behave as if they were competent. This display of competence required DMTs to behave as if they had the authority which may not always have been delegated to them formally. The business of assuming the power that formally resides with the DHA authority might have been made easier for the DMT because so many of the DHA members were new themselves and unsure of their role. DMT members might have been in new positions but were selected because of their previous experience working for former AHAs.

Medical professions had recognised interests which were different from those of the authority members. They did not accept the competence of officers so easily but were, on the other hand, less concerned with it. Perhaps this was because their power was not dependent upon their position within a bureaucratic hierarchy, but had its source of strength elsewhere. Their apparent concern was more to do with working within the organisation.

The agreement of the medical professions, the nursing profession, and the staff unions were less necessary to the DMT and officers because they did not have the same ability to veto as the DHA.

Each of these interests had to be consulted, but the DMT could argue against their objections, provided the DMT presented its own argument to the health authority. The authority was thus appearing, and only appearing, as an arbitrator in a dispute. Few objections were settled in favour of the objector and not the DMT in all the health districts studied and these were minor, non-structural, objections. This was probably because the DHAs had already accepted the DMTs' case and given them their support. There is one exception to this because, as was described above, in HD 13 the objection was structural, but this was an issue won by the DA, not medical or staff interests, who earlier had had a proposal overruled by his DMT.

Although the outcomes were the same in all cases, the abilities of medical, nursing, and staff interests to take part in the process was graded. The DMT and the health authority, once they were acting in league with each other, always retained the structure proposed in its basic form, while sometimes accepting non-structural alterations.

Generally only the medical and nursing staff felt able to propose alterations to the basic unit structures, the staff representative's interests being limited to comments about gradings and careers.

The formal documentary evidence presents a picture in which there was the required amount of consultation. It does not present a picture in which there was any effective participation open to all people within the organisation. With people outside the organisation, consultation was minimal or non-existent. Where

consultation did occur, limited as it was to the required interests, it was often (to borrow a phrase once used in evidence against the policy making style of the DES, House of Commons, 1976, p70), "too little, too late and with too closed a mind". For in most cases it appeared that the will of the DMT prevailed and that other interests appeared to have accepted this because the officer team was able to gain authority from its DHA members. This initial account is one in which the DMT played the dynamic role, although sometimes overruled by its health authority.

The decisions reached

If the interests expressed in the literature reviewed in Chapter Two (Allen, 1981, Bussey, 1982, and Nichol, 1981) do represent the interests of actors in general, then it was suggested, all other things being equal, administrators would prefer units of management to be based on clinical specialties or on a geographic basis, and that medical and nursing professions would not favour clinical specialities as a basis. The administrators would favour clinical or geographic bases as a way of dealing with their prime problem; that of how to manage an organisation efficiently and how to control expenditure and other health service resources.

While doctors retained so much of their ability to determine the use of resources, it was suggested that administrators would favour any organisation that medical professionals did not favour. Given that DMTs appear, from examination of authority papers, to have had such a large hand in determining the unit structures, it is essential to examine what they did, in the event, propose.

However, in order to do this, it is first necessary to clear up some confusions arising from problems of classifying unit structures by the basis of units.

Problems arise because of the inconsistency of the bases used. HC(80)8 allowed districts to adopt a management structure in which individual units could be based on clients, specialty, geography, or institutions. Districts did not have to adopt one basis for the whole of their services but could, and did, devise units that were a mixture of more that one basis and devised structures in which different units were established on differring bases.

It has been argued that administrators, and in this case DMTs also, have power by virtue of their ability to interpret government guidelines and to provide information. Therefore, their interpretation of HC(80)8 requires close examination. DHAs were persuaded to adopt unit structures of various kinds but the commitment to continuing care as being best organised through units based on client-care services was strong. However, the units that were created as client-care based in most districts did not always result in the management of client-care services with a continuity of care. Many units were established that bore the name of an identifiable client-care group but did not really consitute client-care based units as the DHSS had defined them and as integration might demand. There was an obvious difference in the meaning attached to the term between local use of it and central government's. Twenty-four of the twenty-eight DHAs set up an identifiable unit for community services, although this was not always done in such a way as to enable client-care based units to

be established. The unit management of care for identified client-care groups in the community as well as within hospital and other facilities would be required for the unit to be categorised as a client-care based unit.

This was made clear in the circular HC(80)8 which defined what the government meant by client-care based units through the use of an example. Paragraph 28, in listing the types of units that may be established, stated;

> "c. Client care services, for example a mental illness hospital with psychiatric community services and possibly the psychiatric unit of a district general hospital on the the lines described in the report of the Working Group on Organisational and Management Problems of Mental Illness Hospitals. However, larger client care groups may need to be divided into two or more units, provided their is adequate co-ordination between units."

Accordingly a major hospital caring for psychiatric patients, but with mental illness care in the community being undertaken by a community services unit, was not a client-care group based unit, but either an institutionally based or a medical specialty based unit. Similarly, if elderly patients were treated in a geriatric ward which was linked to other geriatric treatment centres throughout the district but whose day care and home help services were separately administered in a community services unit, then the unit was based on a clinical specialism rather than on client-care. Community services were being treated as a clinical specialty for administrative purposes, and in so doing prevented

other units from being client-care group based. They did not prevent the subdivision of other units, such as acute units by client-care group types, but in so doing, those other units were based primarily on some other basis, and the resulting structures would not allow the organisation of "continuity of care" that was strongly favoured by health authority members. In so doing, there has been some prior division of the structure that had precedence over the client-care group division.

Other classification problems also exist. If two large hospitals in a district have different functions, specialisms, or patient care groups, then it is possible for the DMT to say that those two hospitals are in different units because of a division of the district into units based on either specialty, geography, or client-care. These classification problems can be real in some cases, and have arisen through an overlap of the categories being used, institutions are also geographic locations, for example. Or they may have arisen because of an overlap in service provision, perhaps through local circumstances, so that institutions, for example, may house a number of services with different criteria for registering different patients. But in some cases these classification problems may be regarded as suspect and may have arisen through the desire of one interested party to present the structure as being divided according to one basis, when it was in practice divided by another. Such suspicion might be warranted in HD 7 where a report dated 17th November 1982 to the health authority stated;

> "The nursing structure is designed to allow...., ensure..., take some account of the..., and complement the District's philosophy that Units of Management should be based on patient services/client groups rather than on topography/sites."

and where the units proposed and agreed include a General Unit, a Community Services Unit, and three mental handicap hospitals in a Mental Handicap Unit.

Despite the possibility of deliberate blurring of categories, the problems of classification were, in many cases real ones, and make the task of describing the outcomes complex.

The units decided upon: acute services

Acute services formed the basis for many units, although they were not always named as such. In some cases this was because they were named after the hospital centrally concerned with acute services in the district. Often, though, this was because they were either divided by location or because they were merged with other services.

In ten districts acute services were divided geographically (HDs 3, 6, 11, 13, 15, 18, 19, 21, 26, and 27). In some of these the acute services were placed within the same unit as other services. Thus, in HD 21, two acute units were created; one of which also managed maternity services, the other also managed geriatric services. This resulted from the grouping of small hospitals around large acute hospitals, and so resulted from a geographic division of the district. Where acute services were

combined in a unit with other services because they were within the same institutional location, then it is considered an institutionally based unit for the purposes of this study and not a geographically based unit. This occurred in three of the twenty-eight districts (HDs 16, 17, and 23).

Not all acute services were divided however, some were organised into acute service units and some were merged with other services. Acute services were linked with services for the elderly in eighteen districts (HDs 2, 3, 4, 5, 7, 9, 11, 13, 15, 18, 19, 20, 21, 22, 23, 24, 26, and 27). In HDs 21 and 25, acute services were also merged but into units managing district maternity services. And in HD 5, acute services were merged with the district's mental illness services in a unit that also included a large geriatric hospital.

In ten instances acute services were also found within community service units; those that managed GP or community hospitals (HDs 1, 4, 8, 9, 10, 15, 18, 20, 22, and 23).

The units decided upon: client-care groups

No authority member appears to have spoken for any other basis in principle than that of client-care groups. No health authority expressed support for any other basis than that of client-care groups. Whenever a health authority argued against or opposed a DMT proposal, it did so by arguing for the continuity of care of client groups, and no health authority or individual authority members appears to have opposed any DMT proposal for a client-care

group based unit. Despite this, only four authorities (DHAs 6, 24, 25, and 28) of the twenty-eight were able to adopt client-care groups as the principle basis for units. Even these authorities found it necessary to accept that at least one unit would not be a client-care based one. HD 24, for instance, found that it had to manage its services for the elderly, the physically handicapped and its acute services in one unit. In all, nineteen HDs (1, 3, 6, 7, 8, 9, 12, 14, 15, 16, 17, 18, 19, 20, 21, 24, 25, 27, and 28) had one or more client-care group based units, although some of these, such as HD 17's midwifery unit, were nursing units only. These nineteen districts had other units that were not client-care based. For instance, HD 3 had psychiatric and community psychiatric services placed within one unit, mental handicap and community mental handicap services placed in another unit, and yet another unit for all its other community services. Just as acute services were commonly linked with services for the elderly, it was also common for either mental illness or mental handicap services and the community services to be linked, but in two health districts this led to very untypical outcomes. In HD 23 community services were placed within a unit for priority care groups (mentally ill and mentally handicaped). And in HD 25 four units were established, three of which were "continuing care services units". One of these was for community care, although originally the DMT had proposed just two units; one acute and one for community services. These untypical outcomes were achieved by establishing units that were nursing units only, they did not have a full-time unit administrator each.

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Mental illness or psychiatric hospitals formed the basis of units in twenty-one districts (HDs 1, 2, 3, 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 16, 18, 19, 20, 23, 24, 25, and 28) although in HDs 13 and 23 the mental health units were nursing management units only and were without full-time unit administrators. In sixteen of these nineteen districts (HDs 1, 3, 6, 7, 8, 12, 14, 15, 16, 18, 19, 20, 23, 24, 25, and 28) mental health or mental illness services (the terminology differs for similar services) were combined with the community mental health or community psychiatric services for management purposes to form client-care group based units. In HD 25 the mental health services were client-care based but were joined with the services for the elderly and, for purposes of the tabulation below, are not considered as a complete unit. It would, therefore, be more correct to say that 15.5 of the 20.5 mental health units were client-care based.

In three of the nineteen districts (HDs 3, 20, and 25) these services were merged with geriatric or psycho-geriatric care, and in HD 5 they were combined with acute services. In HD 15, although there was a mental illness unit managing a small hospital, other mental illness services were to be managed by the community services unit because the authority decided that the unit structures should reflect the authority's desire to alter the pattern of care to a community based one.

Mental handicap also served as the basis for units in twenty-one districts (those in HDs 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 18, 19, 20, 21, 23, 24, 27, and 28) although in HDs 13 and 23 the mental handicap units were nursing management units only and

were without full-time unit administrators. In sixteen of these eighteen districts (HDs 3, 6, 7, 8, 9, 12, 15, 16, 18, 19, 20, 21, 23, 24, 27, and 28) the unit was combined for management purposes with the district's community mental handicap services to form client-care based units. In two other districts (HDs 14 and 22), mental handicap services were combined with all the district's community services. This arrangement was made to ensure continuity of care for the mental handicap services of those three districts, but such units are categorised as specialty-based for this analysis because all other community services are treated as a specialty-based. These two mental handicap services were brought under the managerial control of the districts' community services units and it was not the client-care group that was the basis of the units, so formed.

Of those that did adopt mental handicap as a basis, without merging with the community services, HD 5 linked mental handicap with its paediatric services and HD 10 linked its mental handicap services with its geriatric and psycho-geriatric services in a non-acute and rehabilitation unit.

Notably, of those districts that adopted the client-care approach in principle, as a basis throughout their services, three of the four (HDs 6, 24, and 28) identified both those with mental illness and those with mental handicaps as client-care groups.

Thus mental illness and mental handicap services formed a large proportion of the forty-one units that were client-care based. This is demonstrated in the table below.

Client-care based units

Mental handicap	16	(39.00%)
Mental illness	15.5	(38.00%)
Midwifery or Child health services with maternity services	8	(19.00%)
Elderly	1.5	(4.00%)
Total number of units	41	(100%)

Units in two of the categories used in this table amount to 1.5 and 15.5 because the table also includes, as one client-care based unit, a unit in HD 25 which was established for both mentally ill and elderly client-care services.

Midwifery or maternity and child health services sometimes formed the basis for a unit. This occurred in fourteen districts (HDs 5, 7, 8, 13, 14, 15, 17, 19, 20, 21, 22, 24, 25, and 28), although in HD 5 paediatric services were merged with mental handicap services into one unit. In eight of these fourteen districts (HDs 8, 17, 20, 21, 23, 24, 25, and 28) the community child health services were merged with midwifery or maternity services into client-care based units, although in four of these (HDs 8, 17, 20 and 23) these were as nursing units of management only. In the remaining

six districts it was decided that these services would be managed separately from the community health services. In so doing, the districts were treating these services, as well as their community services, as a clinical specialty (obstetrics, paediatrics, or midwifery), or possibly as an institutional one.

The units decided upon: in summary

Some general statements about the pattern of units can be made using the distinctions made above. Client-care was adopted as a principle for the division of the complete district in four of the twenty-eight districts, but other districts decided upon on client-care groups as the basis for some of their units.

Districts appear to have decided that client-care was a useful basis on which to manage services for some clients rather than others. These groups were the mentally ill and the mentally handicapped. A large proportion of these services were organised on a client-care group basis. For other client-care groups, however, this preference was not so clear. For example, community child health services were merged with midwifery services to form client-care based units in eight of fourteen districts where mothers and children were identified as a patient group. In six of fourteen districts the DHAs divided these services along other lines than a client-care basis.

HC(80)8 may have served as a prompt to districts in suggesting that people with mental illness could serve as the basis for a client-care based unit but it is an important feature of the 1982

reorganised health service that people with mental health problems should be identified as a client-care group. Client-care groups were not defined in other ways, such as; all people under the age of fifteen regardless of their particular medical conditions. Such a unit basis would ensure the integration of mentally and physically disabled young people with others of the same age range. Age could have served as a defining characteristic in units for the elderly, again regardless of their medical condition. Such possibilities were never explored and the reasons for this must remain hypothetical at this stage but must reflect ideologies in one form or another. Either such radical changes to existing patterns of provision would be too expensive, in which case the ideology at work would have been related to the values of economic efficiency, or such changes reflect medical preferences for treating and nursing people with mental health problems within the same medical specialty or institutional confines.

Acute services are clearly not client-care based, and the way in which it was decided they would be managed, ie; combined with geriatric or other services, or in which they were divided geographically, suggests that acute services were regarded as an area that would be more appropriately managed in units with an institutional basis, not a clinical specialty.

The degree of consultation was markedly different between the two regions whose districts' documentation has been examined. So units decided upon in the two regions were tabulated by the four bases identified in the literature, and then ranked. Of the 134 units formed in the two regions, forty-eight were based on a

clinical specialty, forty-one were based on client-care groups, twenty-six were geographically based, and eighteen were based on or around institutions. Regionally, the unit bases are tabled below.

	HDs in SETRHA	HDs in SWTRHA
Client-care	28 (37%)	13 (22.5%)
Geographic	16 (21%)	10 (17.25%)
Specialty	24 (31.5%)	25 (43.00%)
Institutional	8 (10.5%)	10 (17.25%)
Total	76 (100%)	58 (100%)

Client-care based units were the preferred type formed in the SETRHA, while institutionally based units were quite a long way down below the others in this region. In the other region the second choice of SETRHA districts, clinical specialty based units, were preferred and nearly twice as many as were formed as on a client-care basis in districts in SWTRHA.

The preference expressed by DHAs and DHA members for client-care based units was noted earlier and was expressed quite explicitly. The value of other unit bases was only expressed implicitly, in assessing whether client-care based units would be economic or efficient. Health authorities and member working groups viewed client-care based units as preferable unless there were reasons why they should not be used as the basis. This bias was reflected in the table above which demonstrates that the outcomes across the

two regions differed, while the involvement of members differed.

A simple distinction was made between those DHAs where member involvement was high and those where the DMT retained a large measure of the responsibility. In the first column below are those districts where members had special meetings (HDs 13, 22, 27, and 28), those districts where members had attended seminars (HDs 8, 15, 18, 23, and 24), and those districts which established member working groups (HDs 8, 10, 12, 13, 17, 18, 19, 20, 24, and 27). Although these were taken as an indicator of member involvement, no distinction has been made to take account of the degree to which member working groups were instrumental in effecting the decision, and involvement based upon informal meetings is excluded. It is, therefore, only a crude measure of involvement, but necessarily so. It would, in any case, be quite wrong to regard any measure of involvement as amounting to a dichotomy between the districts concerned here.

	Number of units in HDs where DHA member involvement was reported	Number of units in HDs where DHA member involvement was not reported
UNIT BASIS		
Client-care	26 (42%)	15 (21%)
Geographic	11 (18%)	15 (21%)
Institutional	3 (5%)	15 (21%)
Clinical specialty	22 (35%)	27 (37%)
TOTAL	62 (100%)	72 (100%)

Such a distinction reveals both a marked preference, among those districts where member involvement was high, for client-care based units as opposed to geographically, or institutionally based units, and a different rank order in the pattern of units arrived

at. For where member involvement was observably higher, client-care groups were preferred as a unit basis just ahead of clinical specialty for the units formed. Institutionally based units were a very small proportion of units formed. Where member involvement was lower, then clinical specialty was a clear favourite as a basis, although, proportionally, was not much more preferred as where member involvement was higher. The other bases were all used in equal numbers but some way behind the preferred choice of clinical specialty.

The formal evidence summarised

Before moving on to the results of the survey, it may help to set out the picture presented by examination of the formal evidence. As this chapter has demonstrated, it is possible to interpret the formal evidence at different levels none of which is entirely satisfactory. In the event, there have been areas of doubt in the pictures presented by any of the accounts attempted. It was these areas of doubt that were used to design the survey. How this was done was described in an earlier chapter. The initial account was based upon consideration of the formal evidence alone. It thus corresponds to the first dimension of power, decision-making. It provides an account of the recorded facts, about which more certainty can be placed than in the other accounts attempted. For example, it is possible to claim that authority members in DHA 14 were influential in shaping the units structure. Here, the minutes stated;

Chapter Four
Reorganisation: the formal evidence

> "Members received detailed information on the proposed administrative structure which had been amended as requested in respect of the linking of mental handicap services with the community, and not mental illness."

The consequence of this initial account was the representation of the processes as one in which the primary actors were those most visible in the formal processes; the authority's members and officers. The initial account represents this relationship as the main arena of conflict and presents decision-making as the resolution and management of conflict. The initial account results in a picture in which DMTs appeared to have been attempting to steer the issue of reorganisation over some kind of obstacle race, in which approval by the health authority was the highest hurdle.

The initial account demonstrates what is not known, or knowable, from the superficial examination of formal documentary evidence alone. It was useful, however, in suggesting possible alternatives. Such an account failed, for example, to explain why it was that different DMTs were able to choose to involve their authority members, in the decision, to differing degrees. Furthermore, such an account fails to explain the many variations in DMT's preferred options, for while DHA members were clearly in favour of one basis, no such consistent view was expressed by the officers.

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The initial account left unanswered many questions, for example, there was nothing in the minutes and papers to suggest why it was that districts found it more appropriate to manage mental handicap and mental illness in client-care based units. There is equally nothing to suggest why it was that other possible client-care groups, such as maternity services (as happened in HDs 8 and 23) were not generally considered as a basis for unit management and were thought to be more appropriately managed in geographically, institutionally or specialty based unit. An explanation for these can be constructed from assumptions made about different parts of the medical profession seeking to influence events in competition with each other.

Considering the formal written evidence, as here, is inevitably to consider only part of the picture. The evidence is unrepresentative because it consists of only one type of all the possible forms of evidence available. For instance, the role of informal discussion may have been crucial in the process. Peoples' views cannot have been determined at the point at which they were presented for formal consideration. However, even informal conversations, about which there is little evidence, could only have been conducted within the assumptive frameworks, or ideologies, prevalent within the NHS. If other conceptions of power than decision-making are used in the analysis, less certainty can be attached to what is said. Nevertheless this is what must be done. Moreover, as was discussed in earlier chapters, this must be done according to some criteria. The events need to be explained in a way that accounts for the variations observed and for any inconsistencies in the

observations. As in doing a jig-saw puzzle, the pieces must fit.

The formal evidence fails on its own to suggest why it is that DHA memberships became involved. In some districts, members became actively involved of their own accord. DHA 28 provides an example of the members taking an active role in opposition to their DMT's proposed policy. There were also districts where the DMT attempted to restrict their members' involvement with varying degrees of success. Other DMTs encouraged member involvement by setting up seminars and by providing very full information on the options available, as a basis with which members could be knowledgeably involved. When able to consider the issues relatively free of their members' involvement, DMTs and officers appear to have favoured institutional or specialism based approaches to unit structures, in their policy proposals. This contrasts with the suggestions, described earlier in Chapter Two, that they would prefer geographically-based unit structures (Knowles and Dennis, 1982, Allen, 1981, Gourlay, 1981a, Sturt, 1981, and Allen and Nichol, 1981).

A way round this inconsistency is suggested by interpreting the outcomes. If it is assumed that other actors in the organisation were influential, then a different picture emerges which is still consistent with the documentary evidence and which also accounts for some of the inconsistencies remaining in the initial account. This further interpretation is also able to suggest further avenues of enquiry, and address questions that could only be answered by the further research planned. By not relying on the documentary evidence at face value alone, it is possible to

propose an alternative account of the decision-making and political processes which is both deeper and broader. The next section briefly describes some of the main features of this alternative approach.

In this approach, the major power relationship is not the one between the officers and the health authority but is, instead, the relationship between the bureaucracy (chiefly the officer team but often also the DHA members) and the medical professionals. Here, the DMTs were faced with the necessity, or the opportunity, to make a choice between various courses of action, when the reorganisation first appeared on their horizons. Their choice was constrained to differing degrees, but it was their choice first. They were the people to whom the reorganisation first appeared as a matter of priority and they were the people who first presented it to the membership and the health service staff.

One course they might have chosen was to commit themselves to a radical change in organisation. In terms of power they may have committed themselves to a reorganisation that enabled them to get done those things they wanted done, and in the way that they wanted them done. They may have considered that choosing such a course would allow them to deal more effectively with what they regarded as the central problems of administering the NHS. (In making this choice they would have tried to anticipate the reactions of the other key actors in the organisation. In observing that DMTs may have been making this judgment, it is not necessary at this point to confront the question of how DMTs framed their interests; whether they were their "real" interests

or whether they were false and came about through the processes of organisational or social control.)

However, adopting such a course would involve them in making a judgment about whether they could gain the support of their incoming new authority members, and whether they might encounter opposition from the medical profession. In the light of this judgement, DMTs may have preferred to adopt a more conservative course, that of attempting to devise a unit structure that they judged to be more in tune with professional interests.

DMTs were in the strategically important position of knowing the authority members better than the medical professionals knew them, and of knowing the professionals better than the incomming authority members knew them. Such a choice would have been akin to what Haywood and Alaszewski (1980) described as "managing the mutual adjustment process".

It is also essential that the doctors' expressed desires be treated with just as much suspicion as those of the administrators. (To do otherwise means making an assumption that doctors' power is greater than that of administrators. It means assuming that doctors are free to express their interests when administrators are not.) Consequently, expressions of real desires must be regarded with the possibility that they have causes rooted in power relationships. "Real" desires may have been framed in a social organisation whose values were dominated by others. The health authority minutes and agenda papers described in this chapter certainly provide examples of attempts being made to influence organisational values. The efforts involved in

organising seminars and in justifying policy proposals could all be said to constitute organisational socialisation. As well as plenty of examples being provided of the second dimension of power in operation (issues not being opened up for full discussion, or being presented in one way that, by exclusion, prevented it being seen in another way), there were examples of issues being presented in the very terms and structures that other power groups would have used and determined. Thus when in HD 19, for instance, the DMT stated in an introduction to a paper that;

> "The three main branches of the medical profession are hospital practice, general practice, and community medicine."

It is not possible to ascribe with any certainty how the DMT formed this view. It is a view that the DMT may have adopted and thought important for its further deliberations on the unit structures, but the minutes and recorded thoughts are not necessarily an adequate description of the actual or real interests of the DMT and officers. It was a particular statement made to the DMT's authority and although it may be a view that officers arrived at, while considering the reactions of others whose thoughts, influences, and perhaps actions, lie outside the formally visible procedures, there is no way of knowing if the DMT considered this view important, only that they considered it an important statement to make.

Once the importance of the relationship between the officers and professionals, and of the central position in the relationships that DMTs occupy, is recognised, it is possible to provide a richer account of the events. The literature reviewed in earlier

chapters suggest that the medical profession is best not viewed as one homogeneous profession but one in which different professional specialists enjoy different statuses. As obstetricians or paediatricians, are said to have more influence than those concerned with the mentally ill or the mentally handicapped, an explanation is at hand for the way in which client-care groups were established in those areas where the mentally ill and handicapped were served. Those higher powered professionals were, assuming this particular power league, more able to resist such tendencies for their own specialties.

So, although DMTs may have wanted change, it is possible to understand why they might not have proposed and steered through more units that were not specialty or institutionally based. This is an interpretation of the events that implies that DMTs may have been responding to the second dimension of power. The literature appearing in the professional journals of the period suggest that, not only would administrators prefer different bases for units of management than medical professionals, but that they were also very aware of the importance of delegation. Both medical professionals and administrators, in these writings, made it clear that they wanted the maximum delegation. Doctors had long expressed a desire for delegation down to local level, and the 1982 reorganisation was in part, brought about in order to answer the criticisms expressed by medical professionals that decisions were taking too long, or were not occuring at all. It was also argued that delegation down to local level suited senior administrators as it set them free for strategic management and freed them from the interference of medical professionals

attempting to influence operational decisions at the highest levels of management. The importance of delegation in considering these particular power relationships is not the amount of delegation, but the how of delegation; to whom would decision-making, or power, be delegated to, and what would be within their scope or control.

This second account cannot be said to be inconsistent with the observed data and so is at least as plausible as the initial account which used the observed data alone. The observed data is, of course, suspect for all the reasons outlined in earlier chapters. So, the initial account forms but one representation of the events and cannot be considered merely as factual evidence. Just as agendas are set by political actors in the organisation, the minutes also fulfill a number of purposes for those that are politically active and have legal authority. They are not an account of discussions and decisions made by disinterested observers but an account made by people involved in the processes. Furthermore, their account was agreed as a record with a specific readership: people engaged in the provision of health services. (The likelihood of a lawyer or a social scientist examining them might have seemed remote.) Furthermore, the account they present has to be agreed by the very same political actors. They form an agreed record of what those political actors in the organisation accept as a representation of the facts. Before such a record could be agreed upon, a great deal of information was filtered out, despite their overwhelming length. It is because these documents were agreed as a record that they are valuable in reaching an understanding of NHS organisational ideologies. But

their nature as ideological product as well as documentary evidence is also useful in the interpretation of the decisions.

Being "at least as plausible" suggests, of course, no reason why the latter account developed in this chapter should be adopted as the truth. However, it has merits simply because it allows for the recognition of other relationships than those that are formally observable through the minutes and agenda papers. Its danger is, because it does not rely upon the observable data alone, then reliance is placed upon an understanding of the social and organisational relationships that is drawn from a selective reading of the social policy literature. This means that an assumption has to be made that the literature has something to offer, even when that literature was not always consistent. (It also means making an assumption that the selection of relevant literature has been soundly made.) It means that, having accepted that administrators work in a bureaucracy, the interpretation presented is one in which they have conformed, in their behaviour, to the "ideal-type" of a bureaucrat. Furthermore, it also means accepting the view, presented in the literature and perhaps widely believed throughout the organisation, that certain categories of people have certain interests and that their behaviour can be known and predicted because they will pursue these interests. The validity of these conventionalist assumptions was questioned in previous chapters.

Fortunately, a further alternative is possible. The analysis above suggests that the outcomes of the 1982 reorganisation could not have been predicted from any predetermining factors. Instead

it suggests that outcomes came about as the result of decisions and postures adopted by various people and that these were adopted as the result of judgements made between the force of their own perceptions of what seemed an ideal way in which the organisation could be shaped and the force with which they expected other actors to act in accord with their own desired ends. Postures and opposition were, to some extent, framed by the expected response of others as well as the notions of those adopting such positions. They not only had a desired end, but were also aware of the marginal utilities and costs likely to be incurred as a result of others pursuing their desired ends. The important point, however, is that such postures and judgements were made within an assumptive framework, or an ideology. That is to say that actors were both living in, and re-creating, an organisational world in which basic values were affirmed and re-affirmed.

Chapter Five
Health districts transformed, 1982-1985: devolution

Introduction

District Health Authorities (DHAs) were established and formally took over the running of local health services on 1st April 1982. The previous chapter used documentary evidence to demonstrate how health districts established their management arrangements and their units of management. Following on from that work, four health districts were selected for use in a survey which made it possible to examine the reorganisation and the operation of power in greater depth. The reasons for this choice were detailed in Chapter Three but were essentially to with thé necessity for encompassing all types of political process observed. Once categories had been observed (by process and by outcome), the choice was made by random selection. In keeping with the need to preserve anonymity, these four health districts (HDs 6, 7, 12, and 23) have until now been refered to by a system of numerical identifiers. To make the description of the survey's results easier for the reader to follow, however, psuedonyms will now be used. This is possible now that they are to be discussed alone, and will continue to preserve anonymity. The psuedonyms to be used are Heathdown (HD 6), Milham (HD 7), Dunhurst (HD 12), and Wimbury (HD 23).

The process that went on within health districts which led to a decision on unit structures showed how parts of the bureaucracy and how medical and nursing professionals thought that different parts of the service should be managed. These thoughts, and how they fitted in with the rest of the conceptual framework they associated with the organisation of health care, were central to

the arguments and debates that led up to the different unit structures which resulted. The resulting structures differed because different conceptions of appropriate management arrangements gained acceptance as credible (or, at least, were acceptable). The documentary evidence showed that medical and nursing influence on the final structures which resulted was relatively weak. The officers of the DMT had far greater influence, although it was impossible to disentangle how much their proposals, as presented in DHA minutes, were influenced by the need to consider and accomodate medical and nursing reactions.

The documentary evidence also suggested an association between the extent of involvement of DHAs and the degree to which health districts adopted a structure which was radically different from the functional management arrangements that were typical of pre-1982 health districts. The intention was to cast the net wide enough t · include districts which appeared to have differed both in their political or decision-making processes and in their outcomes. So, the four health districts surveyed were selected because they differed from each other in two key respects: the degree of DHA involvement apparent, and the extent to which their unit structures differed from those prevalent before the reorganisation in 1982. In making this selection, the intention was that the investigation should not exclude any district(s) which differed in these two key respects. However, the focus of investigation was to be on their common experience of power. To recapitulate, these features are tabulated below.

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Health district	Units established in 1982	
Heathdown	4	(2 client-care based units + 2 geographically based units)
Milham	5	(2 client-care based units + 2 specialty based and 1 institutionally based units)
Dunhurst	5	(2 client-care based units + 2 institutionally based and 1 specialty based unit)
Wimbury	6	(3 client-care based units + 2 institutionally based units and 1 specialty-based unit)

(NB. Dunhurst and Wimbury were districts where the involvement of DHA members in the unit structure proposals was recorded.

Heathdown and Wimbury were districts which established more radical structures because at least half the units were client-care based.)

The documentation examined in the previous chapter concentrated upon the period leading up to and immediately after 1st April 1982. It stopped at the point where the issue no longer appeared on the agendas for DHAs to consider. However, there was more to the reorganisaton than was considered formally by the DHAs. The reorganisation was intended to alter the processes of decision-making, devolving them to a more local level. Health districts did not wake up, on the 1st April 1982, to a new organisation complete with all the delegation of reponsibility that was intended. Only certain things occurred on that day. Other things, such as the delegation of operational management, virement within units, and DHA responsiveness to local needs, had still to occur before it could be said that the NHS was reorganised. Some of these things were, in the event, to take some years to achieve and some, in some cases, were not achieved in full by the time of the interviews.

To illustrate this point, Unit Management Teams (UMTs) were to be established, as one of the provisions of the circular HC(80)8, to manage each of the units. HC(80)8 laid down that these were to continue on the well-established principle of management by consensus and were to consist of the Unit Administrator (UA), the Director of Nursing Services (DNS), and a medical representative. While the UA and the DNS held line management responsibilities and were accountable upwards, the medical representatives at unit level did not. Similarly, to further illustrate this point, the survey revealed that relationships at the strategic management level had been, if anything, less stable. District Management Teams (DMTs) and DHAs entered a period in which their relationships were to begin and then to develop. The composition of the DMTs was similar to the UMTs except that the District Treasurer was included and medical representatives were found from both clinical and general practice. These were also to operate on the principle of management by consensus and so the agreement of both medical and nursing professions, as represented by these people on the DMT, was essential to decision-making.

These two points illustrate that the reorganisation which started with the establishment of DHAs in April 1982 was something which involved the changing of roles over the period since. For instance, the roles played by the chairperson of the DHA and by the District Administrator (DA) developed in ways which were particularly significant only after the first six months. This chapter and the next report the results of the survey and show how these relationships and others developed. How these relationships worked out in practice is crucial to understanding the operation

of power and the decision-making mechanisms established by the 1982 reorganisation.

The survey demonstrates how these relationships continued in a state of flux after 1st April 1982 and did not remain static. The 1982 legislation did not establish a fixed pattern of stable relationships but established a position in which relationships would continue to develop. Research suggests that before the 1982 reorganisation the role of officers had been limited to managing the "mutual adjustment process" (Haywood and Alaszewski, 1980, p142). Administrators were described in the second chapter as "fixers" or as "enablers" (Paine, 1978) for the medical professionals whose demands were paramount. And, in Scotland, officers had been described as being puzzled by the uncertainties of who should arbitrate between competing claims for development funds (Hunter, 1979). The evidence from the survey will show that, what can conveniently be called the 1982 reorganisation as if it all happened on the 1st April 1982, resulted in changes in power relationships at district and unit levels which continued over a period of some years.

Since 1st April 1982, central government has imposed a number of radical policy changes on health districts, some of which are directly concerned with decision-making, responsibility and accountability. They were significant then to this study of power. Nevertheless, the 1982 reorganisation has not been superceded by any further legislation although certain of its provisions have subsequently been altered significantly. The reorganisation has to be regarded as part of a process of change

for, while it may be convenient to associate changes with particular dates or events, such as the establishment of DHAs on 1st April 1982, these dates and events were merely steps taken towards a transformation of the NHS as an organisation. (Incidently, this is a view which would surely be supported by Sir Roy Griffiths. He has been quoted saying that 'Large scale change is never a single event, it is a process.' Halpern, 1986).

In the opening chapters, the power relationships between central government and local health districts were discussed. No firm conclusions were possible between the opposing views expressed by researchers about whether the centre was ultimately all-powerful or whether its power had been delegated away. The delegation of power and authority is a complex matter for the reason that any complete statement about the removal of power from once source to another has to say whether it was "given" rather than "taken". The discussion of the centre-periphery debate showed just how the arguments could go round in circles. The results of this survey, and described in this account, illustrate further that power is not something which can be located at any specific source. These chapters will add to the centre-periphery debate, in describing the devolution of power and authority away from central government to local health authorities.

Relationships in the four health districts, of course, did not develop in similar ways. Nor did they develop at a similar pace. There were a number of other features about each health district's situation which make comparison difficult. Nevertheless, they shared the necessity (or the opportunity) to respond to the

policies of central government within similar legal and financial constraints. The common necessity to respond will be used as a means of comparing the four health districts and also as a way of dividing the period into separate stages when the districts were in comparable situations.

As a result of this process of change, decision-making and power both operate in different ways from when the Conservative government of Mrs Thatcher was elected in 1979. One of the more recent steps taken has been the appointment of general managers and the adoption of the general management function. By the end of the period covered by this research, DGMs were being appointed whose role was defined in terms of their having a personal responsibility for planning and managing their local health services within the resources available. In getting to the point where general managers could be appointed, the role of officers developed considerably from the rather limited, reactive, role they once had. This development reflects a transformation in the processes of decision-making within the NHS. How this organisational transformation was achieved within the four health districts surveyed is the subject of this and the following chapters.

The interviews for the survey were conducted just as DGMs had been appointed in each of the four districts. Their appointment would obviously bring about great changes in future decision-making and while no attempt is made here to evaluate these changes, the impending onset of general management had a profound effect on relationships within the districts which began very early on. The

knowledge that management changes were to be made in future directly affected working relationships within districts and the roles adopted by various people. Therefore, the NHS Management Inquiry, even before its findings were published and its recommendations adopted by government, was an inescapable factor to be considered in using the 1982 reorganisation to demonstrate the operation of power. The implementation of its recommendation that the general management function should bring to an end the long-established principle of management by consensus brought an end to one of the specific provisions of the 1982 reorganisation. Because this principle was fundamental to the ethos of health care organisation and management in the NHS, it was no minor event. It serves as the point at which the 1982 reorganisation can be assessed, having run its course. So, the period covered by the survey starts sometime before 1st April 1982, when districts were planning and preparing for the reorganisation, and continues until the summer of 1985, when DGMs were taking over the reigns and consensus management teams were being disbanded.

Some DHAs used the implementation of Griffiths as an opportunity for altering the unit structure that had been established in 1982 in addition to the internal management arrangements that had to change; others did not. Just how much progress had been made by each health district in implementing the Griffiths style of management at the time people were being interviewed is an important factor and one which will have to be noted, particularly when comparisons come to be made. Comparison between the districts will, in any case, be complicated by the fact that they were not being introduced to a set pattern. Under the 1985

changes, the management arrangement whereby districts were to have a DMT and Unit Management Teams (UMTs) each managed with the consensus of a trio of officers and medical representatives was no longer required. Instead, there was no single management model that DHAs were obliged or expected to adopt. Nor, for that matter, was there a standard definition of the general management function to which they were obliged to conform. The result was likely to be a much greater diversity of local management structures and styles than at any previous time in the history of the NHS. Such diversity would obviously make comparisons between health districts difficult, as the districts were heading in different directions.

Although the point has been made here that the 1982 reorganisation took place over a period and that the events occuring over this period should be regarded as a transformation rather than as a series of events, it is convenient to divide the description of this period. The survey evidence presented here will therefore be covered in two chapters, this and the next. First, there was the reorganisation itself as it initially affected the strategic management levels of decision-making. Evidence concerned with this stage is reported in this chapter. Then, the districts and units began to be affected by the actions of central government to such an extent that in some cases the "intended" delegation to units was not completely carried out. This more complex stage, in which the provisions of the 1982 reorganisation began to be buried under the preparations being made for general management, is described in the next chapter. While these two chapters divide the transformation, they do overlap and merge with one another

when considering the transformation as a whole. It is this whole period that is intended to shed light on the operation of power within the NHS, and so the next chapter will conclude by drawing out those significant pieces of evidence that will be used in the final chapter.

Two things need to be noted about the reporting of the survey's evidence in this and the next chapter. First, in concentrating on these four health districts, greater attention will need to be given to describing their characteristics than was necessary in the previous chapter. In order to preserve the confidentiality under which the survey was conducted, all names will be presented, for example, as A..... Hospital. The letter used will not necessarily be the same as the initial letter of the name. Second, as in the previous chapter conventions need to be adopted for the sake of brevity. The use of "DHA" will be confined to the District Health Authority in its formal sense, and not to any of its officers and staff. When the whole health district is to be referred to, it will be as Heathdown health district, for example.

Devolution of authority and delegation of strategic management

This chapter examines the immediate effects of reorganisation upon the power of the medical professionals on the one hand, and the bureaucracy, on the other. The survey showed that the immediate effect of reorganisation was, generally, a weakening of professional power relative to a strengthening of the power of the bureaucracy. However, the generalised concept of "bureaucracy" needs to be broken down into its constituent parts if these

relative shifts in power are to be explained in adequate detail.

The first section describes how the 1982 reorganisation had immediate effects within the bureaucracy of the health districts surveyed. This shows that, once the district officers had been appointed into their new posts, there was a relative weakening in the power of the DHA and its members, with the exception of the chairperson. The district officers employed by the DHAs were able to increase their power. This was particularly so of the DA. The chairperson and the DA, then, were both able to increase their influence to the point where their relationship emerged as being the most significant. The chapter then shows the effect this had on medical and nursing influence. These were reduced because both were content to rely upon the fact that they had representatives on the consensus teams. Medical influence, which was stronger in the first place, was particularly weakened by this mistaken reliance. They felt that their influence would be retained through the cogwheel system, the medical executive committees, the representation on the consensus teams, and their representation on the DHAs. They then became vulnerable because these were by-passed to some extent by the administration and because the DHA did not have the power they thought it did have by virtue of it being at the top. In many ways, then, their power was reduced because of the attitudes that prevailed among them towards management and structures.

To illustrate why the attitude of the medical professionals was misjudged, the effect of the reorganisation upon the DHAs and their officers needs to be explored in detail. First, the

relationship between the DHA members and officer teams need to be described. As part of this, the extent to which DHA members were involved, and how much this may have influenced the decision taken will be described.

In the documentation produced by the health districts and analysed in Chapter Four, Heathdown stood out as the only health district where radical change from pre-1982 arrangements had resulted with no visible DHA involvement. This fact alone was responsible for the district's selection for the survey as it appeared to contradict the conclusions reached in Chapter Four about the greater involvement of DHA members and the extent to which client-care based units were established. By all accounts, however, while the officer team had indeed been more responsible than the DHA for the proposals, the structure ultimately arrived at was not as had been proposed and was not to the officer team's liking. In fact, the DHA's members had exerted some considerable influence on the unit structures decision, as will be seen, but what makes Heathdown so unusual was the extent to which outside influences had shaped the decisions reached in 1982.

At the beginning, in 1982 when the district was established, each of the officers had each proposed a management structure for their individual disciplines. These had been, almost without question, accepted by the other officers on the team. Like many of the other health districts analysed in Chapter Four, the issue of unit structures and management arrangements had been closely linked. The officers successfully subsumed the unit structure issue under discussion of their management arrangements, a concern that was

seen as their legitimate affair, and thus one that DHA members were relatively happy to leave to them. The DA explained why he thought this was;

> "Generally, all the chief officers were able to produce their own structures in 1982 with very little interference from the DHA. In fact they were new - green - and didn't know much about health care and we could get away with it (as it were). It was officer-led very much and the Authority, asking questions perhaps, but not having the detailed knowledge to challenge."

The DA described himself as the prime-mover but working with colleagues so he thought it was a team effort, although each officer was "left to get on with his own bit." His own concerns in 1982 were very much to do with the ways decisions were to be taken in future. He described his main task in 1982 as "To look at the senior management committee structure." The senior officers had met fortnightly before April 1982, and this was changed to monthly. He tried in 1982 to delegate to individual officers and junior groups of people tasks which had previously been done by the DMT. He said;

> "So, it was to do with how things get decided, who decides them, and how often people were meeting together .... It was mainly about definitions about who did what."

This was because, he said, before 1982 when the health authority had been 25 miles away;

Chapter Five
Health districts transformed, 1982-1985: devolution

> "...there had been more opportunity to do your own thing .... With an Authority in the patch, I think it required a very much clearer definition of who was doing what: what was the Authority going to do, what the DMT were going to do, and in particular, the relationship between the chairman and myself."

The fact of the DHA's lack of involvement in this health district's efforts at reorganisation in 1982, was confirmed by all the other officers. The explanations offered for it were also similar. However, respondents admitted, on the specific issue of the district's unit structures, that the DHA had had some influence. According to the District Treasurer (DT), the DHA members had been happy to leave much of the work relating to management arrangements to the officers but had then discussed the issue of unit basis on "many subsequent occasions but not as an Authority." (This would account for there being no minutes of these discussions.) The DA also admitted that the DHA had had some influence over the unit structures. Asked whether he thought the choice of basis for the new units was an important issue, the DA replied that it was the most fundamental decision that had to be made. "It was", he said, "a very important philosophical point to hammer out properly. I think probably the Health Authority had more influence on that, but not on the management structures." The reason he thought this was that "the Authority had a lot of influence on finally chosing geographical against Community/Institution - more functional - care-group basis, but that was probably because the officers allowed that to happen." Although he now thought the issue was "fundamental", he had not originally thought so because he added that this was because;

"they (the DMT) didn't feel strongly one way or the other. It was left open and therefore the Health Authority felt free to come to its own decision."

That said, clearly the DHA's discussion was conducted within a certain context. The freedom of the DHA to come to its own decision might, of course, have been somewhat limited. As the DT pointed out;

"Having chosen their chief officers and their chief officers having reached agreement amongst themselves, and it was within the limits set by Region, it wasn't too difficult to persuade the Authority that it was OK."

The work in devising unit structures for the district and management arrangements was clearly left to the officer team and particularly the DA. The DMT had no difficulty, initially, in persuading its DHA to adopt a unit structure that would have comprised two geographically based units. The district is unusual in having two district general hospitals within its borders and the intention was, in the DA's words, "to have a comprehensive health care structure" with "units which would contain all the elements of health care for a geographic location." One of each of these two hospitals would have been within each of the proposed units.

However, at this point, although not minuted, the DHA made the first of the changes that were to be made to the chief officers' original proposals. There was, according to the DT, "a very long debate, continuing debate about what the basis of the units should

be." Concerns were expressed that, if the district adopted the proposals for geographic units, "...poor old community services get left out all the time. It is always the hospitals that grab most and he who shouts most gets most, and they feared for the development of community services." At the end of the debate, the DHA apparently accepted the proposals, accepting that integration outweighed the risks. However, they felt that services for the mentally handicapped was "a special service and should be protected and highlighted as such. And the only way they could do that was to make it a separate unit." Accordingly, a separate Mental Handicap Unit was decided upon.

The same debate also occurred over services for the mentally ill. Eventually this debate led to changes being made to the officer's proposals, although of a less significant nature. Here community mental illness services were separated from one of the two geographically-based units, while in the other it remained integrated. So a Community/Psychiatry and Mental Illness Unit was established for part of the district's territory.

So, having secured far from total agreement to its proposed structure from the DHA, the DMT then embarked upon the statutory consultation processes and it is here that the plans received further amendment. The analysis of the documentation in Chapter Four suggested that once proposals had been approved by the DHA, there was little chance of them being altered, although medical and nursing professional groups were not unwilling to try. In Heathdown however, the consultation process led to further significant change. The reason for the success of those consulted

in getting changes made was that some of them were able to obtain the backing of people outside the district. The proposals were opposed by the psychiatric nurses, the occupational therapists, and, most significantly, the midwives. It was the opposition from the midwives that led to the further changes because the Royal College of Midwives protested to the Regional Health Authority (RHA) because the plans did not include a separate midwifery unit. The psychiatric nurses also appealed to the RHA but, as was seen above, were only partially successful. The success of the midwives in winning this particular battle is not accounted for by any arguments they may have put to the DMT or the DHA. Both these bodies remained convinced that, in the chairperson's words, "You didn't need to be one to manage one." The consultation involved a Regional Consultation Committee which, apparently, came to see the district's officers and chairperson. Region (whether the RHA or its officers is unclear), said to them that because they wanted to do something which was slightly more radical than others, if they carried on, they might hold up the whole reorganisation in the region. In the chairperson's words;

> "They forced us to, blackmailed us, because we were the only one. It was holding up the whole of the restructuring in the region. We had to create a separate midwifery unit for management purposes."

So it was not the internal processes of consultation themselves that secured success for the midwives. The result was that the 1982 reorganisation came to be seen by the DA in retrospect as "a very prescriptive reorganisation... very complicated and very

heavy in the way it was applied."

By 1985, when interviewed, the DA clearly thought that, in those areas where they had given way to pressure, mistakes had been made. He may not have thought that at the time, something which might explain his acceptance of them then, but in 1985 he regarded them as "unforgivable". The DA explained;

> "I think we made a few fudges on accountability.... They [pharmacists, physiotherapists, and occupational therapists] had a dual accountability. A local accountability for their day-to-day work and a professional accountability to medical officers and people like that which is a nonsense managerialy. So I think that would be something I would not feel proud about. But I think in terms of the way the organisation was divided up - it wasn't a bad go at it. The geographical arrangement works here and has proved to be right."

To back this up, he added;

> "To run a community service from a hospital 10 miles to the north proved very complicated, because people actually want to talk to their colleagues in the hospitals in the north, not go through a structure in the south."

The survey in Heathdown illustrates, first, that the documentary evidence was quite misleading in giving the impression that the DHA's involvement was low. For while the DHA was not involved in making the initial proposals, it was instrumental in changing them as a result of pressure from both within and outside the district. Second, the survey shows that the RHA's officers took a role quite

outside that which would have accorded with the provisions of the DHSS circulars at the time. Quite clearly, this could not have been minuted by either the DHA or the RHA. Third, it shows the extent to which the midwives and psychiatric staff could go in order to change things and the extent to which such a strategy could be successful. The notion of delegated authority was not accepted by these staff groups. They went higher up the hierarchy once they saw an arrangement they did not like being accepted by the DHA. The undermining effect this might have had on the DHA should be noted. Finally, it is possible to conclude from this that the officers were powerful in the sense that they were in a position to propose structures to suit their own requirements but were always at risk of having their proposals overruled by their DHA. However, as will be seen, this became less and less likely after reorganisation.

Turning now to Milham, the documentation examined and described in Chapter Four suggested that it was similar to Heathdown in not having significant DHA involvement in the decisions reached in 1982. The survey confirmed that this was indeed the case in this health district. Here the DA in 1982, a man who had left in August 1983, was the person most responsible for the district's unit structure and management arrangements. His reputation as a powerful figure in the district had remained long after his departure. In 1985, Milham's DT described him as having "a great deal of personal authority" and when asked to describe the role of the DHA members said;

"The role they had was almost at the margin, in terms of haggling over which particular service ought to be controlled .... A good example was perhaps Child Psychology where it was up in the air as to whether that should be a service managed by the Mental Illness or Community Unit. In the end it was the subjective feelings of the members that where Child Psychology naturally fitted into other care provision that led to that forming part of the Community Unit."

Many responses, in interviews, have to be regarded as being coloured by the interviewees' self-importance. (The pilot study had demonstrated this particularly and made it impossible to say with any certainty who had influence there. In the survey, however, interviewees were pressed harder about the role of others and this made it possible to disentangle self-importance from that importance which could be confirmed by others in the district.) Nowhere was this more so than in the responses of Milham's chairperson who, others warned, would claim to have a greater influence than others would be prepared to credit him with. Nevertheless, his response to the questions put to him about the involvement of the other DHA members suggest why, and how, their involvement was limited in Milham. He said;

"Well obviously it was discussed with officers because, when we formed the DHA, I was the only one, apart from a few who had been members of the CHC [Community Health Council], who really knew how the health service worked. And so I had to involve, for their sake and for the sake of the service, the officers who were still, perhaps, Area Health Authority [AHA] officers. I

had to ask them to give us advice."

This view was confirmed by Milham's *Nursing Officer. When asked* who had influenced restructuring in 1982, he said;

"Yes, the DMT... The medical view other than that, seemed to me to go along with what had been proposed rather than attempt to influence. It's very difficult to say what role the members played. Many of them in this District were new to that role at that time... It is the chairman who is a retired physician and former vice-chair of the AHA who was very involved at the time. Didn't ever seek to say 'do it this way please, change that', he was almost a member of the team."

The influence of the officer team was also confirmed by the DMO who, in response to a question about who influenced restructuring in 1982, said "I think the Administrator, perhaps the Treasurer." When pressed about the influence of members in the formation of units, he responded;

"Not a lot, I think they're playing more of a role now in so far as they understand it now but they were newly appointed then. No they weren't all fresh to the NHS but some of them were and I think that a new DHA, meeting once a month with very little sub-committee activity, ... I think, generally speaking, they accepted what was put before them."

The reason supplied here for the relative weakness of the DHA compared with the strength of the DMT during this period was confirmed by the Chief Nursing Officer (CNO). He said;

"I think we were largely a team that had been in being from the years previously. There had been changes during the years but all the people appointed to the management team had been in being and were fairly clear [on] where we felt the District should go. We wanted to have units of management that were related to patient services, patient needs, rather than buildings, geographic locations, sites, this sort of thing. And we structured our units on these lines."

While the CNO claimed that patient-care services were the basis of the district's unit structure, he admitted;

"We had some problems as a number of our sites are mixed and a number of our services extend into the community.

This is the point at which the versions provided by the various respondents in Milham conflict and become confusing. Most respondents claimed that the district had organised itself with predominantly client-care based units. The CNO, for instance, regarded the establishment of a Community Unit as a client-care based unit, despite the definition provided by the government in HC(80)8. Nevertheless, Milham was a health district in which the officers had led all the time and the result was a unit structure in which management arrangements corresponded closely with the institutions in the district. There were two truly client-care based units, but they were outnumbered by two institutionally-based and one specialty-based units.

In summary, no attempts were made by either medical or nursing staff to alter the DMT's proposed structure. Compared with Heathdown, officers in Milham were able to take a much stronger leadership role. They went unchallenged by the medical and nursing staff who made no attempt to put alternative proposals to the DHA or any higher authority. Perhaps they had no alternatives to propose, or perhaps they guessed that they would not get the support necessary. However, as will be seen, the more likely reason for this is that they were simply not concerned. The strength of the officers' leadership in relation to their DHA can be explained because the health district was formed by the division of one AHA into six DHAs. It meant that the proportion of experienced members recruited onto the new DHA was relatively small.

This was a situation similar to that in Dunhurst which was also formed by the division of the same large AHA. The structural outcome was quite similar too. The documentary evidence suggested that Dunhurst was one of those where the DHA was involved in the decisions taken in 1982, but that the unit structure was not a radical alteration from the functional arrangements that typified many health districts before the 1982 reorganisation. The implication of this is that no radical changes had occurred as a result of the involvement of the DHA's membership. In this health district the relationship between the DHA and its officer team was unusually tense, at least when compared with the other three health districts included in the survey.

In 1982, Dunhurst's DHA had been involved through a working group of members and had arrived at a structure that showed little change from typical pre-1982 arrangements. It is therefore questionable how much real influence the DHA had in 1982. The chairperson, when asked whose formal agreement was necessary in 1982, admitted;

> "I can't recall how that came about. It was generally accepted that the DMT position, or the ethos of having a DMT, was going to be perpetuated. I don't recall submitting a proposed structure or anything. Have you found it elsewhere? I can remember the unit structure being agreed at Region but I thought it was fairly standard throughout the service that a DMT was set up with that."

The member interviewed also confirmed that the DHA had little influence on the district's initial organisation. Among the first tasks, according to this account was;

> "Getting to know the composition of the management structure of the District so that we could take it over as a going concern."

According to him, this lack of DHA influence was because the reorganisation had no effect on the power of the Regional Health Authority (RHA) and its officers to set the overall policy in which health districts had to work. "Region", he said, "very definitely retained the prime responsibility for providing the service, determining what levels of service it hopes to provide in each District." He explained this by saying;

> "Region forms such a helpful buffer between central government and the people who are actually delivering and receiving the service.... Very useful to central government."

The member said that the members had never been involved in the 1982 reorganisation. "It never became clear to members", he said;

> "We just muddled on from decision to decision which the officers told us it was time to make because Region had now said that this could be done.... So we muddled on, accepting gratefully really, the next task that was allotted to us by Region."

The member said that he had recognised the fact that choice between the kind of units the district were to have as fundamental. "But," he said;

> "at the same time one had recognised that one was being pushed by what one had already got and the need for providing continuity of management into a structure that was, more or less, ready made."

Most respondents, however, attributed influence to various sources within the district, without referring to outside constraints. When asked who had had the most influence in the development of the district's unit structures and management arrangements, the chairperson replied that the DA (now retired) had. "The structure was put up by him" he said, but qualified this by saying "he and I had a fair amount of input, although other members of the DMT and the Authority were very much involved as well."

The DT described the DMT as a very powerful and cohesive team. Asked about the DHA members, Dunhurst's DT said;

> "No, to the best of my recollection, it [the units decision] never featured as a major part of debate. Partly because it was nearly there anyway. There were a few things they debated - the only thing looked [at] was the problem of the various circulars; the changing role of the various officers, District Works Officer; change of accountability of Unit Works Officer and Unit Administrator, that sort of stuff."

Being involved was, of itself, insufficient to ensure DHA influence. The above provides a clue to why this was so because in Dunhurst the management arrangements were the subject of reorganisation before 1982. The district's mental handicap unit had recently become a separate unit just before the 1982 reorganisation and was kept as it was. According to the DT, arrangements in the district evolved since 1974 and this was given a big impetus in 1978 when there was a staff protest over alleged harsh and unfeeling management in a mental illness hospital run by the district. This was national news and, although it did not lasted long, resulted in two inquiries. A very elaborate management structure was established there and it started people thinking about unit management teams. Accordingly, the 1982 reorganisation formalised management arrangements that were already developed in the district. Dunhurst's DT said;

"In actual fact the unit structure was in existence prior to that date. There were some minor modifications .... but we always did have unit management .... It all seemed so obvious to be quite honest. We didn't write great erudite papers and, you must remember that in many respects in a multi-district area, management at district level was much simpler than it is now. Much, much simpler. The power of the DMT was enormous, much greater than it is now. The poor perishers with six Districts just ran around in circles, the area members. The officers were, at area level, in many ways a post-box - the gatherers of information from six districts."

From the officers point of view, the most significant thing about the 1982 reorganisation for this health district was that its case for more resources could be put directly to the RHA instead of being put first to the AHA without success. The officers were looking forward to having this direct link with the Regional Officers, and did not anticipate, rightly at first, that the new local DHA would add to their problems. It was issue of the district's financial straits that occupied their thinking, almost to the exclusion of organisational issues. The interviews in 1985 revealed a tendency to adopt a relatively derisory attitude among officers and medical professionals towards their DHA members. This attitude continued at least until the appointment of the DGM.

Asked whether the members had played any role in the formulation of units, the CNO replied;

"Not initially, no. I think when members were first appointed they were not aware of the implications of serving on a DHA - either from the time commitment that it was going to take, or of the type of power bases they were going to come across in the NHS, the type of decisions they were going to be expected to take or rubber-stamp (varying views there). Some wanted to know why things weren't being put to them in the format that they could adopt while others were saying they always wanted options placed before them. And certainly they didn't think at that time that there would be occasions for anybody to be concerned about the responsibilities of the DHA living within its budget."

Again the DMO confirmed that the DHA played little part in reorganising the district in 1982. Asked who had had most influence, she replied, "I think as an officer team we all worked well together." When asked whose formal agreement had been necessary for the new management structures, she replied, "It doesn't seem a very appropriate question - the structure didn't change much."

Most officers expressed the opinion that little changed at the time and the DT claimed that little attempt was made to alter previous arrangements. However, it seems there was some attempt to disband the Community Unit and to link community services to other hospitals because Dunhurst's DMO claimed an influence in resisting that idea. She said;

"I would say I was in agreement with what we decided. How much my personal view caused that decision to be made I think is very doubtful because we have so few facilities that really it was fairly clear what the unit structure had to be unless we went down to very few units."

Some changes were made, however, although they were regarded as being so small that they were not immediately included in respondents' answers. One pre-1982 sector, comprising three hospitals, was divided into two units with the main district general hospital in one unit and two smaller hospitals in the other. Also the community nursing structure was divided into three sectors within the Community Unit because it was felt that meeting the needs of 290,000 people was too large a span of activity. Another complicated alteration was that the previously separately managed unit for mental illness was changed. After 1982 the large mental illness hospital, which was outside the new DHA's territory and which had been the subject of an investigation while managed by the old AHA, was treated as a separate entity. Planning matters which related to this hospital, the district's community mental illness services, and mental illness services at its district general hospital were treated as one but the hospital was otherwise managed separately. The chairperson hinted that this might make it easier for the Region to decide upon its closure or for another district to accept responsibility for its management.

The lack of major organisational change was reflected in the district's attitude towards its personnel. According to Durhurst's chairperson, the 1982 reorganisation was implemented with a deliberate policy of "minimum turbulence". He said;

> "we felt that if someone had been doing a job for a goodly number of years - if they weren't up to it they should have been disciplined before, and if they were doing it satisfactorily... it was right that they should have their own job."

Despite this policy, turbulence ensued because several senior managers retired at the time of reorganisation, including the DA. There were disruptions as other staff at lower levels in the administration left too. The DMO claimed that, apart from the other members of the DMT who remained, there was only one person in the district headquarters who had been there three years earlier.

In Dunhurst little attention was given to the reorganisation of the district's units and management structures. This alone explains the absence of medical and nursing staff challenges to the officers' authority: the issues simply were never on their agenda as a subject for consultation. The DHA members involvement was limited.

Like Dunhurst, Wimbury was categorised, in Chapter Four, as one in which the DHA had been involved. Unlike Dunhurst, however, the result was a decision in which the structure represented a radical change. In Wimbury's case, however, the documentation revealed that DHA involvement only occurred through the attendence of its

members at a day workshop. Not apparent from the documentary evidence, however, was the fact that this workshop was the last of three held in the district. The process was explained;

> "You've got to remember we were in the days of a shadow DMT and a shadow Authority, with the new DMT only getting to know each other and getting to know the Authority. So it wasn't a case of everyone immediately being aware of people's views. We involved the help of an outside agency .... to act as a catalyst for us. We went through a lot of internal discussions as well .... We had three half-day or all-day seminars purely on what we wanted to achieve in this District, what sort of service would reflect the principles we should base it on and the first one was aimed at senior managers (chief officers and their number twos) to help formulate their thoughts. The second was these senior people with a good cross-section of middle-rank managers and clinicians, getting their views. The third session was a half-day seminar involving members. Then based the outcome on these workshops. They were workshops which really went back to first principles."

This contrast between Dunhurst and Wimbury is highly significant. In Dunhurst the DMT were used to working as a team and developed their structures virtually autonomously before the DHA arrived on the scene. The DHA, while involved, was not a cohesive and therefore powerful group. In Wimbury nobody knew anybody else and this resulted in discussions in which there was a genuine attempt to get back to first principles, something which was avoided in Dunhurst.

Nevertheless, despite the involvement of the DHA's members in 1982, it was the officers who were attributed with the the major influence. The CNO did not arrive until several months had passed, and influence was first attributed to the DA, (now the DGM), the DT, and the DMO. Nevertheless, the DHA influenced the final outcome because it was subject to the lobbying of people within the organisation and had overruled its officers. Unlike the DHA's involvement in Dunhurst, the initial involvement of the DHA in Wimbury was genuinly sought and welcomed. Wimbury's DMO, refering to the involvement of members, said;

> "We had a number of meetings with them going through it, discussing various issues, no particularly controversial ones. ...Most of it was about the Paediatric/Midwifery Unit, Community Unit, and the Elderly Unit, and they took those decisions in the end. Although what was decided, we agreed with, there was no sense of rubber-stamping. It was discussed very thoroughly."

The decisions reached and agreed with the officers were that the district would establish two acute units plus a Community Unit, a unit for the mentally ill, another for the mentally handicapped and a unit for the paediatric and midwifery services. There was a proposal for an Elderly Unit but it did not have the support of the officers. The DMO, for instance, claimed that he had been intimately involved in the process and had "helped to oppose the idea of a unit for the elderly." By all accounts, the discussions involved a variety of people and interests, either supporting or opposing the vertical or horizontal integration of services. The GPs, for example, opposed the idea of fragmenting services for the

elderly and for paediatrics. "They wanted", according to the DMO, "to foster the primary health care team, so they were against vertical integration." Similarly various parts of the nursing service were involved in arguing for district-wide services.

Finally, despite the influences that various groups had upon the decisions that the DHA reached, accounts confirm that the decisions were ones that the officers were agreeable to. The Deputy DT, for instance, said;

> "They all sat down, big think-tank session. Essentially it was what the then DMT wanted, which is what you'd expect, really."

The DMT wanted a significant number of client-care based units. In particular, this was what Wimbury's DMO wanted. When asked what he regarded as most important or essential at the time of the 1982 reorganisation, he said;

> "I was keen to see some care-group based units. There were terribly difficult decisions about how far you could take it. We never seriously contemplated, and I think it was practical, trying to take that approach across the board."

He added that he "would like to have had the issue forced, so that we could have had it integrated across hospital and community." He regretted that "That wasn't possible but we got it [client-care based units of management] for midwifery, mental illness and mental handicap."

In sum, Wimbury demonstrates that even with the genuine involvement of all concerned, the officers were still able to get a decision from their DHA they could be satisfied with. The medical and nursing staff, as in Heathdown, were able to influence the DHA's decision on structures but only marginally. As will be seen later, this had little effect because once the DMT established itself, it felt able to ignore the DHA's decision.

Devolution of authority: summary

Having traced the reorganisation as it affected DHA members, chairpersons, and officers in each of the four surveyed districts one-by-one, their differences and the things they share in common can be summarised before showing how medical, and nursing, interests were weakened.

The four districts surveyed were selected because the documentary evidence suggested that they all differed in major respects. However, the survey evidence suggests that they also had many features in common. The first and most obvious of these is that each of the DHAs consisted of members who were, by and large, new to the health service. Members in each of the health districts had little or no experience of its complexities particularly in comparison with their officers. It should be noted that the DA was a new appointment in three of the districts used in the survey. (Heathdown is the exception: the DA had been in post there since February 1980.) However, newly appointed officers, such as DAs, had a much easier task in getting to know the complexities of their health districts than DHA members attending

meetings in their spare time. In any case, they were already aware of these at a national level through their previous experience in the NHS.

The relative weakness of DHA members was particularly marked in Milham and Dunhurst and so has particular relevance here because these two districts were particularly influenced by their officers, and were where the unit structures were the more conservative. In contrast, the DHAs in Heathdown and Wimbury were able to overrule their officers and decide upon unit structures which included more radical, client-care based, units. (In both these districts, the officers regarded these arrangements as anomalous and, as will be seen, ensured that they would eventually be disbanded.)

(However, it should also be noted that these two districts had another feature in common. Heathdown was formed with an urban area and a district general hospital at each end of the district with twenty miles of rural countryside between. Wimbury was formed by the merger of two, previously separate, districts. As will be seen, this was to have a particular effect upon medical professional power in Wimbury. However, both district teams of officers were initially concerned with the unity of their district. Perhaps this concern resulted in their apparent early willingness to accept the imposition, by their DHAs, of units for client-care groups which would straddle their district. Officers in both these districts referred to the need to gain unity, even if they did not regard the need for unity as a sufficient excuse for accepting these anomalies. Unity mattered less at the time of

the survey, when both districts were disbanding their client-care based, cross-district, units in favour of either a geographically or institutionally divided structure. However, this is to consider later developments too soon.)

The second point to make is that members were also, by and large, new to each other and consequently were each unsure that their understanding of what their role should be was shared by other members.

Third, this lack of experience meant that most members were not only unsure of their role, but uncertain of their decisions, and prepared to accept the leadership of those who they thought had greater experience. In contrast to the inexperience of many DHA members, some members had considerable experience of their district and or the health service in general. Such people might easily have provided the leadership that the newer members were looking for. The chair was usually occupied by such people and so the possibility arose for the chairperson to gain a prominent position, relative to the rest of the membership, in each of the districts. In health districts such as Milham and Dunhurst, where the DHA as a whole was relatively inexperienced, the chairperson was almost the only member the officers had to consider seriously. His agreement guaranteed the agreement of the members. This was not the case in Heathdown and Wimbury where, in both cases, the chairperson was, along with the DMT, overruled by the DHAs in their acceptance of client-care based units.

The power and influence of the chairperson relative to all the actors involved, not just the membership, is harder to determine. Their position could be reinforced by a strong association with their DAs and the way that this relationship developed was crucial later. The chairperson was regarded, by both DHA members and DMT members, as a member of the DMT. The role given to the chairperson by the DMT varied. At the outset, they may have been regarded as a representative of the DHA members in much the same way as the doctors were regarded as representative. Later, integration with the DMT may have been fuller but initially they were both part of the DMT and yet different. The chairperson in Dunhurst described how his DMT had never had to work with an Authority chairperson before and "tended to put me on a pedestal".

The fourth and most crucial point to make, however, is that the district officers established a role for themselves in which they became more powerful than any other group. Not that they were always able to get the DHA to make the decisions they might like, although that often happened. The officers succeeded in securing for themselves, or the DMT as a whole, the right to make decisions that related to their district's resources. Ultimately they were to be centrally concerned with decisions on service development and planning. They were able to do this through a combination of two major factors. The first of these was the relative inexperience of most DHA members. However, there was a small delay before this became important because, at the outset, many officers were worried about their future jobs. The other major factor was the way in which DMTs began to work.

Chapter Five
Health districts transformed, 1982-1985: devolution

District Management Teams: consensus decision-making

Most respondents spoke of the speed with which decisions were being reached after 1982 in comparison with before: no-one contradicted this view. This was partly because decisions no longer had to be refered to Area Teams of Officers and AHAs. DMTs benefitted from closer proximity, after 1982, to their DHA members and chairpersons. This proximity meant that they could decide things, and be seen to decide things, much more quickly. The potential disadvantage they might have suffered from this proximity making them less autonomous and more open to scrutiny could be countered by their cohesiveness.

Reading accounts of consensus management, such as that provided by the NHS Management Inquiry (DHSS, 1983, pp 11-12), it would be tempting to believe that consensus management was ineffective. Nevertheless, the officers clearly were influential in deciding their district's management structures. Even in those districts (Heathdown and Wimbury) where the DHA overruled their officers, events since show that the officers were eventually in a position, to alter arrangements in accord with their wishes. In Wimbury, district officers even felt able to ignore their DHAs's decision!

The NHS Management Inquiry may well have been right in many of the things it said. The NHS may well, for instance, have been unconcerned with measuring it's performance. However, the inquiry team's concern that general management be performed by an "identifiable individual" and that "responsibility drawn together in one person" may have prevented it from seeing any value in consensus teams.

This is not to say that consensus teams were without difficulties. It could be hard for teams to reach consensus, for instance, when their membership included medical representatives without any line management responsibility for their clinical colleagues. The possibility always existed with consensus teams for someone to veto or delay decisions. Prevarication or procrastination may have become typical in many districts. Or else decisions might have been taken which were unclear. The NHS Management Inquiry remarked that consensus management can lead to 'lowest common denominator decisions' and to long delays in the management process. Nevertheless, there was little recognition of this expressed on the part of those interviewed in the four health districts surveyed.

The evidence suggests, instead, that DMTs developed ways of working in which responsibility was usually attributed to one or other of its members. Moreover, they felt able to take decisions in a variety of areas without feeling it necessary to obtain first the commitment, or agreement, of their clinical representatives.

It has already been shown how much influence the DMT had in relation to its DHA. For example, in Heathdown each of the officers had proposed a management structure for their individual disciplines. These had been accepted, almost without question, by the other officers on the team. The DA had described himself as the prime-mover but working with colleagues so he thought it was a team effort, although each officer was "left to get on with his own bit." In Heathdown, the work of devising the unit structures and the management arrangements was clearly left to the officer

team and particularly the DA. If this description of DMT working relations, and those from other districts, are drawn together, it can be seen that DMTs could be effective decision-makers by adopting a strategy in which mutual respect for each others' agreed responsibilities played a central part. This does not mean that they never argued or disagreed. Instead, each officer took responsibility for presenting a proposal or policy to his or her colleagues. This was by mutual agreement of the team members. In some circumstances the proposal could be questioned and rejected and then presented at a later occasion. Usually however, it was accepted because the team, without individual members researching the issues for themselves, accepted that the proposer knew what he or she was talking about: they accepted each others knowledge and experience. This kind of arrangement, which can be viewed as a strategy adopted to cope with the continual possibility for failure inherent in consensus teams, was described in greatest detail by some DMT members in Dunhurst. These members were particularly aware that consensus management could work effectively because more recently they hade become aware of its failings. It may seem inappropriate to select Dunhurst, where according to Dunhurst's DT this arrangement had all fallen apart after the 1982 reorganisation, as an example. After 1982, he said;

> "the team personalities were a disaster. [The DA, the chair, and the medical representatives were new: the CNO, DMO and DT remained the same.] We were all picked for our individual ability but nobody had worked out that it was more important to work out whether we could work together."

However, the DMT's earlier strategy shows how consensus could be made to work.

According to Dunhurst's DT, the DMT's development of the district's unit structure had been "a very corporate effort." He said;

> "The team was superb - apart from the District Community Physician at the time, who was one of those who used to sleep at the mad-hatters tea party, and was a non-entity. The other five worked together very well, respected each other's territory, knew each other well socially, and had an almost telepathic intuition as to what they needed to do. Very very rarely was there a tremendously heated debate. It was usually each person putting in a little refinement from an initial paper put forward by the person who everybody agreed ought to know the answer."

He said, "We learned very quickly that the academic definition of consensus wasn't really a practical proposition." So the DMT developed decision-making by "the acknowledged leader of the proposition, modified by that person in the light of the debate and that modified person being accepted by the other members of the team." The DT said there was natural leadership on each front and little challenging of that role. He claimed, "No challenges of their right to be the one to put up the initial idea to be chopped about and altered."

The responses of the CNO and DMO both confirmed the working of these arrangements. Without detailing the DMT's working relationships, Dunhurst's DMO said;

"I think as a DMT at that stage we worked very well together. We had an excellent DMT about this time. This is one of the disasters that Griffiths has brought about - relationships have taken a .... But we had a very good working team prior to '82 and just after '82. We worked well and collaborated well. Our chairmanship used to rotate, so it was a fairly democratic DMT. [The new DA] just took his place amongst us."

Unlike the DT, the CNO thought the DMT had continued to work well and consensus management was still proving valuable. In commenting about consensus management, the expression of concerns about general management were inevitable. In expressing her concerns about general management, Dunhurst's CNO said;

"I would always maintain that if something went to our DMT and it didn't go through on the first occasion, in eight out of ten times I'd say it was right that it didn't go through.... The added discussion to it enabled some changes to be made to the proposal that brought about an improved recommendation - and ultimately better implementation and better service."

Another of her responses detailed this further;

"We do have an Authority that would never make a decision on anything to do with nursing without hearing the nursing views. The DMT may try - but knowing full well they won't get away with it. I think we have that kind of mutual respect for each other now that we may try and tread on each others grounds but we know we'll get our fingers burned off. We still try because that means there's good discussion on points. So, I think that is

very healthy and certainly not the case here that if I take an item to the DMT, it gets through because it's nursing and the nurses put it."

The CNO in Dunhurst also said that the 1982 reorganisation made a difference to the DMT's workings, although not as extreme difference as the DT had claimed. Of its effects on decision-making, she said;

"Within the DMT it became more important that the DMT make a decision on something before something was put to the Authority. This had not been as apparent when we were working with Area because we were rarely asked for a DMT decision by Area. It was just not as apparent that we were needing to reach consensus on anything ...."

So, despite the different perspectives of these respondents on their DMT's more recent decision-making, particularly on the value of the right to challenge a proposal, they held the opinion that general management might put at risk something valuable. However, the DMT had found a way of making consensus management effective by determining responsibilities in advance. Nor did this preclude discussion. It was not an arrangement which prevented DMTs reaching decisions. (The "lowest common denominator decision" was more likely to occur at UMT level than at DMT, as will be seen in the next chapter.) Moreover, there is evidence that similar strategies were adopted in the other DMTs.

In Heathdown, for example, the way that individual officers on the DMT were able to devise their own management structures supports this. The DT devised the structure for the finance office. It consisted of 40 posts and only two of these were deleted at a later stage. His proposals, like those of his colleagues on the DMT, were accepted by the DMT. The DA however, who when interviewed had recently become the DGM, expressed the view that the DA was responsible for "...communication - bringing major issues to the DMT, and for ensuring that whatever was decided was communicated." However, he added;

> "There was no-one's task, no-one grasped formally at the task of getting things done - implementing. And I think that was a failure of the system and where consensus management really wasn't very wonderful.... You could argue down the problem rather than argue it up and, therefore, to rely on consensus as a decision-making mechanism isn't healthy."

Such opinions may have been coloured by the onset of general management in the district and it is not possible to state how long this opinion had been held. It contrasts with others expressed in Heathdown. Heathdown's DT clearly felt otherwise. He said;

> "Much has been made of the management by consensus not working and the popular belief that [it] meant government by the slowest or by the lowest common denominator. That has not been my experience here from 1978 until recently."

He dismissed criticisms that supporters of general management might have put by saying;

> "I can only recall, in all truth, the lack of consensus being obtained twice. You might say that that surely argues for the Griffiths thing - it proves that if you haven't had a break in consensus then you must surely have been the lowest common denominator because it really isn't possible to have four or five years without major conflict in a decision-making set up.... Of course you have conflict but you don't necessarily, like choosing the Pope, you don't leave 'til the white smoke comes up."

The DT then went on to describe how consensus had worked in the DMT, and in so doing, outlined what he thought were the conditions necessary for consensus to work. He said;

> "I can see no problem in sitting down and putting a point - going to a meeting and doing my homework - particularly those points where I can and should have an opinion and being allowed to put it. Having put it doesn't stop someone else having an opinion and a contribution to make. And I see nothing wrong in going to a meeting and being persuaded by the argument and by the facts. And I see nothing wrong in being convinced by another person - someone who you respect in a particular field and who has demonstrated over a period of time that he or she is trustworthy and is a capable person in that particular field. In other words, there is an element of trust and an element of persuasion and there is an element of partnership about the whole thing."

It may be argued that general management need not do away with the kind of discussions and the persuasion that DMT members feared would no longer prevail. The point being made, however, is that general management was intended to prevent a kind of decision-making that many respondents denied was occuring. They were often prepared to admit that it could happen and to concede, therefore, that it probably did happen in other health districts. However, with few exceptions, some of whom were people who had become DGMs, respondents generally denied that they had experienced it themselves.

The difficulty in stating any uniformly-held judgement on the value of consensus management is that frequently the necessity to reach consensus meant compromise and compromise can often be regarded negatively. As Milham's DA said;

> "One of the problems that did arise from [consensus management] was that there was a tendency for DMTs to wish to avoid a conflict situation because what it meant was that they then had to admit to their chairman and their Authority that they didn't agree. [Which] many DMTs felt reflected directly on them, directly on their capability of running the service. So, as a result you sometimes got compromise for the wrong reason. Not compromise for the reason that people were eventually convinced by argument."

He then added;

"Equally, having said that, I think there were many Districts in the country where the consensus management approach worked very well. Whether it worked well because all the people worked as a team or whether it worked well because an individual took the lead anyway, or whatever the reason, ... it did, in fact, work."

These quotations serve to illustrate several important points about the way DMTs could work together. First, of course, the principle of consensus management had its faults. Second, these faults were recognised by those working in consensus teams. Third, their responses to these recognised faults varied from the ideal (in which all participants debated and then agreed a common course) to the less than ideal (in which a common course was agreed merely so that the DMT looked capable to its DHA and other observers). Fourth, whatever the response, the effect was that the DMT presented itself as a cohesive group - at least in comparison with other decision-making groups.

This fourth point is probably what gave the DMT its power. As a decision-making group it might consistently take "bad" decisions (in the judgment of others) or it just might not work together effectively, but its cohesion made it difficult for inexperienced and uncertain DHA members to argue with. This bears on the issue of professional power because the medical professions took little interest in the decision-taking forums established in 1982. They felt that their interests were safeguarded because they were represented on the DHA. In fact, many medical respondents expressed the view that they welcomed the 1982 reorganisation

because it brought the DHA closer to them.

Medical representation

Professional power, as was seen in the literature reviewed in the first two chapters, operated at several levels. One of these was seen in the ability of the medical professions to veto decisions taken all the way through the *organisational structures*, the committees, of the NHS. Another organisational form of power was seen in the cogwheel system set up so that clinicians could bargain and negotiate for the equipment and facilities they needed. Neither of these two forms of medical power looked, at first glance, to have been affected by the 1982 reorganisation. The provisions of the legislation appeared to keep them intact. The cogwheel system continued and the new management structures included places reserved for the expression of medical opinion. The ability of medical professionals to have things put on the agenda for decision-making, or to have things removed, looked unaffected by the reorganisation. (For this reason, perhaps, no great medical anxiety was seen to be expressed, as has been seen more recently, with the establishment of the principle of general management.)

All respondents were asked to comment on the extent of medical involvement in management and policy making in their district. With the exception of people in Wimbury, they found this a difficult issue on which to comment. Clearly it was an issue they had thought about but, in general, they were dissatisfied with the results. Many were surprised at being asked to comment, perhaps

they regarded medical involvement as absurd. Generally, their response was either to refer to the way in which medical opinion could be expressed through the District Medical Executive Committee (DMEC) and through medical representatives on UMTs, the DMT, and the DHA or else to comment on the lack of any medical interest in being involved. Only in Wimbury was the question understood in terms of clinicians taking an active role in the management of budgeted resources. More typical was the response of Heathdown's DT who, for example, said;

> "We have, I suppose, a little more medical involvement.... There always was a DMC and the chairman of the DMC always was, and still is, the DMT member - consultant representative.... Similarly the GP was a member of the medical committee and a member of the DMT. We have advisory committees at each hospital and have always had them before the new set-up. The thing that changed then was - there was an opportunity for, say, the chairman of the local management committee, Hospital Management Committee to become a member of the UMT."

Within the four health districts surveyed, the attitude of professionals towards the reorganisation of 1982 could fairly be described as apathetic. As an event, it passed almost unnoticed by some, particularly those working in general practice. Consultants were more aware of it but, even so, awareness was limited to those who made it their business to be involved in the decision-making of their districts. Most respondents pointed out that their involvement was reluctant and had come about because no other medical people had shown interest.

In Milham the GP interviewed had been on the DMT for three years and then had become the GPs representative on the DHA six months earlier. When asked why, he said;

> "Interesting question that, I often ask myself. I often wonder what brings a doctor into these areas of administration."

After then talking briefly about his sense of vocation and of duty, he added;

> "And I have for years been vaguely involved in the Community Physicians and GP Division here, chairman of the Medical Staff Committee of our local cottage hospital, that sort of thing. And when this came up usually nobody wanted to do it, and I thought I didn't want to do it but sort of drifted into it and one thing led to another. My name was put up for the DMT and once I'd done that, it was a logical progression. The fellow on the DMT before me was a DHA member for three years, and I'm taking over from him."

The GP interviewed in Dunhurst described how he had come to be the GP representative on the DMT. He said;

> "I was asked to be the deputy as the chap who was doing it that particular time found there were quite a few occasions when he couldn't attend, for about six months before. I never attended as a deputy as he then retired and asked me if I would take it on."

In Milham the consultant member of the DMT was chairperson of the DMEC. He said that he had come to the post to be "representative of my consultant colleagues". When asked why, he said;

> "There was a certain amount of arm twisting, if I can put it that way. I'm not exactly a political animal and I think, at that time, there wasn't anybody who was realy keen to do the job. People just looked around and I thought I'd try it for a year and see what it was like."

Again, the consultant representative on the DMT in Dunhurst was also the chairperson of the DMEC. When asked why he had taken a place on the DMT said;

> "I did it because I was asked. It was Sod's Law, really. Somebody had to do it and I was asked to do it. I didn't seek it out."

However, he added;

> "I feel quite strongly about the way the hospital works and I suppose if you want to influence the way it works you have to find yourself on various committees. I suppose I found myself at meetings tending to speak up about this and that and once you abandon a low profile - you then get collared. I didn't seek it out as an end in itself, no."

The existence of clinical representatives on management committees was not sufficient to ensure medical involvement. This is because of the way in which they perceived their role on these committees.

The GP representative on Milham thought his main purpose was to protect the GP hospitals which, because the district was "overloaded with GP beds" were constantly under threat from the physicians and surgeons. "Apart from that", he said, "I've no particular aspirations... except that I find it very interesting, meeting other people in the administration."

The consultant representative interviewed in Milham said that he saw his role, on the DMT, as "purely representative". He elaborated;

> "I think the administration have the idea that I'm basically the head man as far as the medical people go and it is for me to chase up my consultant colleagues if they're not doing what they should be doing. I have told them quite firmly I'm, of course, not prepared to be the headmaster type figure and I was basically their representative - representing their views."

In Dunhurst, the GP explained that his "work did not overlap with the district's work as such". He was there, he said, to ensure that the district was aware of the implications on the community services of their decisions. "Otherwise", he said;

> "There are things that I felt I wasn't really - couldn't put my mind to. It's not for me to say that I don't think the orthodontist, say, should get [a particular piece of equipment]. You could always argue, on the patients you see and who needs treatment, you could give an opinion but it would be a very low key one. I think there are quite a few things on the DMT that one is slightly the outsider."

The consultant representative in Dunhurst thought clinicians had been very active in the district's administration. He claimed that his predecessor had set up the unit structures. This claim was in conflict with all other accounts provided by respondents in the district but may have arisen from the DMT's pre-1982 practice of having their consultant member act as chairperson because, according to the DT;

> "If there was any possibility that we wished to challenge or, in some way, not comply with [Area] Health Authority policy, if he was the one who spoke on behalf of the team - he was not employed by the AHA and he was fireproof."

The contribution of clinical staff was minimal over many years. The present consultant representative's claim that his predecessor had decided the unit structures also described the extent of most clinician's influence. "The rest of the consultants", he said;

> "sat back and just let him carry on ... using his wealth of experience".

The member of the DHA interviewed described their contribution to the district's strategy meeting as a "shopping list". He said "I don't think we've really done anything to try and promote the idea of doctors as managers." Similarly, the chairperson said;

> "... at the end of the day I think the doctors always shield behind this barrier that - right, they realise the problems the District has in living within its budget - but they still have this divine right to provide the best possible service for their patients and they won't accept the responsibility for

budgeting."

The responses given to the issue of medical involvement in management was exceptional in Wimbury. Clinicians had a tradition of being involved in the management of hospitals in parts of Wimbury. The consultant representative on the DMT explained that in the main acute hospital "we've had for a century or so - a Clinical Superintendent - a doctor separated off who ran the hospital along with the others." However, the 1982 reorganisation had the effect, at least for a time, of reducing medical involvement.

Wimbury was formed by the merger of two health districts. According to the CNO, the DMECs in both the previous health districts were, by repute, extremely powerful. The merger reduced their power as both groups of clinicians were distrustful of each other. For two years after the 1982 reorganisation, according to the DMO;

"...we ran with fantastically small amounts of medical involvement. The fusion of the District disrupted the established medical power lines. We had a situation on the DMT where there were two consultants there [one from each of the previous two districts], who both felt they had a watching brief to make sure that their end of the District was safeguarded. And, for a long time, the District was run by the chief officers, as apposed to the DMT, absolutely no doubt where power lay."

The point to establish here is that, even in the exceptional Wimbury health district, medical people were not only reluctant to attend the meetings, they were also reluctant to take any other role than a representative one. They were not willing to interpret their role as one involving the management of resources in accord with any priorities or objectives. They did not think of it that way. Instead they were concerned to safeguard what they saw as their interests or those of their patients. More broadly, they saw their role as to represent their colleagues', and their patients', interests. Some clinicians were prepared to take a reactive, representational, role but wanted to keep matters of administration at arms length. With the exception of a significant proportion of clinicians in Wimbury, doctors did not want to be concerned with management if it was defined, loosely perhaps, as planning for the needs of the district as a whole (however these are decided) within the available resources. Management, if defined thus, is an active process while representation is a reactive one. Clearly then, medical practitioners, if they thought their representation was sufficient, were confusing the power to veto decisions with other kinds of power. Refering to the conceptual distinctions outlined in Chapter One, they were, for instance, not considering the kinds of power involved in affecting the thinking of others involved as to what kinds of services might be provided.

Attempts were made to veto management structure proposals put forward by DMTs in 1982 by both medical and nursing lobbies with varying degrees of success. Midwives in two of the districts were successful in altering the structures proposed in their districts.

A midwifery unit was agreed to - against the wishes of the DMT - in Heathdown, as was seen, after the midwives lobbied the RHA. In Wimbury, the midwives successfully fought to deny the paediatricians a separate unit - although, in the event, the Midwifery and Paediatrics Unit was never operational because the DMT never allowed it to be separately staffed. Also, as was seen in Heathdown, after the midwives launched their campaign of lobbying against the proposals, the community psychiatric nurses attempted to alter the DMT's initial proposals by the addition of units for the mentally ill and the mentally handicapped. The DHA accepted their case for the mentally handicapped and partially for the mentally ill.

Attempts by the medical professions to alter proposed structures were made but with less success. The paediatricians in Wimbury, for example tried to form a separate unit consisting only of themselves. So, in comparison with some nursing staff who demonstrated an ability to change proposed structures, medical staff appear weak. Perhaps, structures mattered less to them and they were less determined, or perhaps they were less certain of success. On balance, the former appears to have been the case. The statements made by doctors during the survey reveal how many of their attitudes influenced them in thinking that representation, or veto power, would be sufficient. One of these attitudes was simply that DHA matters were not of prime concern. As the consultant in Dunhurst said;

Chapter Five
Health districts transformed, 1982 1985: devolution

"No self-respecting clinician will allow himself to be drawn out of the clinical arena into administration to the point at which his [private] practice suffers."

The DMO in Heathdown said something similar. He said;

"There are very few consultants in this District who are interested in management, ... in thinking about policy for the development of services."

Milham's DMO said;

"The doctors aren't interested... The main problem as I see it is private practice. There's so much private practice in an area like this that a doctor engaging in management will lose a small fortune because of the time taken out of his private work. So he has to be either altruistic or in a specialty in which there's very little private work."

Another attitude towards management and administrative structures commonly expressed and characteristic in many of the responses of medical staff was that structures were immaterial and that what really counted, in getting things done, was the personalities involved. Almost all doctors interviewed expressed this attitude. It was expressed forcefully, for instance, by the consultant interviewed in Wimbury. He said;

"I never had any sense of unit structure. I've never felt affected by or interested in or found a great deal of effect on variations of structure. Nearly all my understanding of how things have worked have been through contacts with individual people."

Nevertheless, he went on to admit that the old AHA system had "inefficiences" inherent in it and, thus, contradicted his earlier statement. The consultant interviewed in Dunhurst provides another example. In responding to a question about the effects of the 1982 reorganisation, he said;

> "It sort of worked. I think it lacked the sort of things that Griffiths has tried to bring in now. We seemed to make decisions but the implementation was poor and things didn't get done. Now whether this was a lack of will, or a lack of power, to effect these things - I suspect it was a bit of both. Personalities that just didn't drive through and make sure that things were done."

This premium placed on personalities over structures was also expressed by DMOs. In Heathdown, the DMO spoke about management and general management. He said;

> "I believe in team management but [consensus] has serious drawbacks because it depends so much on personalities. I think if you've got a good team working together with complementary skills then that's probably the best way to progress things. If you've got difficult personal relationships where the group can't work as a team or where somebody tends to veto decisions then I think that's a recipe for chaos."

The attitude that structures do not matter, and that personalities do, is an attitude that bolsters medical reluctance to be involved in committees and administrative work. It is an attitude that might be explained by their observation that reorganising things

did not necessarily change people's behaviour. Reorganisation needs new ways of thinking if it is to be effective, and the means to change people's ways of thinking may not have been sufficiently developed. Seen in the context of the operation of power, the doctors were expressing the view that things which could be labelled or thought of as "management" or "administration" were not part of the medical knowledge they had acquired and wanted to use.

These views, and the consequent reluctance to have anything to do with administration, combined in making the involvement of most medical people marginal to the decision-making processes of the health districts surveyed. Medical professionals retained all their old powers over their individual patients and over the definition and treatment of health and medical problems. However, they were excluded from taking anything but a marginal role in the organisational structures created in 1982.

Exclusion from the decision-making structures of health districts would not, of itself, mean that medical power was significantly diminished. Their lack of concern over this reflects their past experience that medical power was not dependent on these structures. It is also possible that their judgement was correct and that future medical influence would not be truly diminished. However, the point to establish here is that - for a limited time at least - doctors were, in treating administrative matters at arm's length, denying themselves a decision-making role in the allocation of resources, the principle concern of those taking a managerial role. This particular area of decision-making is

crucial because by providing services in one area rather than another, the limits of medical intervention are set out. Doctors were commonly charged (see the first chapter) with having a blanck cheque in the system, effectively deciding what amounts could be devoted to different sorts of care. In practice, they were limited in this to the services which were, or could be made, available. In future, resources were to be attached to units of management and these were to be assigned specific areas of medical and health care responsibility. The units of management and the management structures associated with were to have profound implications for the allocation of resources. This development, the retreat from resource allocation decisions, medical opinion was no longer as vital in setting health priorities as it once had been (under the still existing cogwheel arrangements). Instead, the administraton was beginning to regard this as their responsibility because they were the only ones in a position to decide priorities over which sectors of provision and care were to be develped. In effect, if not in what they said, doctors were no longer prepared to claim that their special training made them uniquely qualified to decide who should be treated or receive care and who should not. This retreat from decision-making - however temporary and despite significant exceptions, such as the clinicians in Wimbury doctors - left others in a position to influence the direction of further health service developments (or cut-backs).

Taken at face value, the combined responses of those interviewed present an account in which medical professionals chose to have themselves excluded from these decision-making and organisational arenas. Lack of medical interest in organisational matters is the conventional wisdom. The experience in Wimbury demonstrates that there is nothing inherent about clinicians that makes them reluctant to be involved. What may be conventionally understood in the other three districts may mask processes in which medical lack of interest was ensured. How these are to be known is, of course, a problem described in earlier chapters. The point established here, however, is that the role of medical professionals in the decision-making of the reorganised NHS was much reduced, not inately low. Personality does not explain this.

In summary, the inexperience of many DHA members placed them in a weak position from which to confront their officer team. Not only did their inexperience mean they were relatively unknowledgeable about many of the issues, but also they were uncertain of their role in relation to the officers. The officers, after a brief period, were able to capitalise on this DHA weakness. During this brief initial period however, while they were uncertain about their futures, they had little choice but to avoid conflict with their DHA. Consequently their proposals could be overruled by a DHA succumbing to pressure from medical or nursing professionals and from RHAs or regional officers. Once they were secure in their posts however, district officers were far more able, because of their greater knowledge, to challenge the DHA. The chairperson of the DHA could be treated as one of their number and could be asked to persuade the other members. Medical professionals were

represented on all the decision-making committees but were not concerned with resources. Consequently, district officers were in a position to select from their claims in accord with criteria and priorities which they had themselves decided in isolation from any knowledgable DHA involvement. Medical representatives were not able to speak for their colleages and were not in a line-management relationship with other clinicians. Officers could therefore choose to ignore many of the things medical representatives said. Representatives, on the other hand, who found themselves by-passed in this way, felt able to rely on more experienced representatives on the DHA. However, the DHAs had little overall influence on policy direction.

Senior nurses, unlike medical professionals, were only represented at district level on the DMT. This enabled the CNO able to make use of his or her line management responsibilities for less senior nurses and so they were able to use the hierarchical structures established in 1982 to good effect. The structures established by the reorganisation suited CNOs well, giving them the internal knowleage to argue as an equal with their colleagues on the DMT where the main source of power was.

Decision-making structures changed in 1982 but also, at that time, there were changes in the kinds of knowledge which were recognised as valid or legitimate in the making of decisions. Crucial to understanding this shift in power is the role of recognised expertise and experience. Under restructuring conditions - where people were new to the organisation - authority was accorded, to those whose knowledge was perceived as being greatest. However,

only certain kinds of knowledge could act as capital in these circumstances. Medical knowledge - even translated as the doctors' unique ability to judge the needs of his or her patients - was no longer sufficient. The situation in these districts, in two RAWP-losing regions, was that needs (or demands) had increasingly to be balanced against resources. This was an issue which the administration was expected to deal with and so their power and importance increased in each district. The Health Authority was also expected to deal with this issue but, in comparison with the administration, its information and knowledge was too weak. The potential existed for the administration's role as arbiters over competing claims for resources to be transformed into a management role. Apart from this resource allocation arena, the sheer volume of decisions which were being demanded of health districts in the period following restructuring in 1982 by government ensured that the administration had to assume a central role. No other group was in a position to cope with the increase in central government's demands. The possibly existed that this new role might increasingly be informed by different conceptions of health care from the medical model which previously dominated health service decision-making.

Chapter Six
Health districts transformed, 1982-1985: delegation

The reorganised NHS: delegation of operational management

The 1982 reorganisation was described by the government as intended to bring about the delegation of authority and of day-to-day management to more locally-based levels in the NHS organisation. The previous chapter examined power in the districts by concentrating on the devolution of authority. This showed that reorganisation had the immediate effect of strengthening the role of DHAs but that this was soon followed by a strengthening of the role of officers. Medical staff were outside of both these developments which together can be considered as a strengthing of the bureaucratic functioning of the districts. Subsequent developments are examined in this chapter. It shows that medical staff, with some notable exceptions, continued to be outside the main changes taking place in the structure of the organisation, and that the officers' position, (particularly the District Administrators') was strengthened further. Eventually, and coinciding with changes made by central government, the role of the officers and officer team was reduced as the District Administrator (DA) and then the District General Manager (DGM) became pre-eminent.

Delegation of day-to-day (operational) management down to Unit Management Teams (UMTs) was accompanied by moves made to strengthen the accountability of managers to the DHAs, and ultimately to Regional Health Authorities (RHAs) and central government. These moves cannot be considered in isolation from one another as, for many, accountability dominated operational delegation. This chapter, therefore, deals with the period that

followed the appointment of district officers, DHAs and the establishment of unit structures. It deals with how the units of management, and their UMTs, were able to respond to the opportunities presented to them by operational delegation of management and how these opportunities were limited. As will be seen, however, medical influence was not a major limitation.

First, to put this in its wider context, it needs to be said that overshadowing this period were the activities of central government. The interviews revealed that these resulted in some officers and members feeling that the government was interfering and hindering the officers in managing their districts. However, as the account will show later, the activities of central government also had the effect of making the officers central to the accountability that central government was insisting upon. Central government ensured that officers, particularly the DAs, had plenty to do and that the activity in the districts centred around them. Officers might have complained about all they had to cope with (and often did) but this activity ensured their importance in the future.

Much of the government's activities consisted of ministerial speeches and official statements. These activities continued as much after the reorganisation as before. After April 1982, the government initiated several policy changes to ensure adequate accountability and to ensure that their view of how the NHS should be managed prevailed in local health districts. As many respondents had previously seized upon the fact that many of the earlier statements made by government ministers had been concerned

with the delegation of accountability and management, it is perhaps understandable why so many respondents now regarded these statements as little more than *insincere political rhetoric*.

This is not the place to catalogue a history of specific instances which were seen as central government interference in health district management. Briefly, however, the period saw the introduction of new manpower targets, a system of annual reviews of RHAs and DHAs, and accountability reviews. Privatisation and the private health sector were encouraged. Uncertainties about future spending levels continued. Most significantly, an inquiry into the management of the NHS was announced in February 1983, only ten months since the establishment of the new DHAs.

Following the formal hand-over to DHAs on 1st April 1982, there were continued central government and Conservative Party comments on how the service should be run, as well as other acts which were interpreted as government interference in management. Instances of this follow. On 24th June 1982, it was announced that four of the regional health chairpersons were not to be re-appointed in July because they had criticised the government's handling of the pay dispute. In a written parliamentary answer on 16th July 1982, the government announced that it was launching a study into the controls on spending on primary health care services and inviting tenders from private consultancy firms for the work. In October 1982, the Minister of Health announced that the government was extending its privatisation proposals to include health care.

Alone, none of these examples might have mattered very much, but together they added up to the continuation of a policy environment which was perceived as central government interference in the management of health districts. It was resented by many people interviewed. This resentment was particularly noted in the pilot surveys. It appeared to have subsided somewhat by the time that interviews were held in the four districts described here but still emerged when some of the respondents were asked to talk about the Griffiths inquiry's proposals which were then being implemented. Indeed, many of the difficulties that some of the districts encountered in implementing general management may have resulted from resentments built up earlier.

Other changes in the national policy environment were both significant and unexpected. Manpower figures had been left alone for many years and health authorities had no reason to expect any change. With reorganisation, they were obliged to reduce their manpower in line with central government targets by March 1984. This change meant they were no longer free to determine their staffing levels within their financial allocations. Thirteen of the fourteen English RHAs protested against this (Times, 17th September 1983) and the professional journals carried articles which criticised the reduced targets. One writer claimed that the reduced targets would "undermine attempts to make the NHS more receptive to local needs" (Allsop, 1983). Considerable pressures were also brought to bear on health districts to privatise their non-medical services. Again, district officers felt this policy took away from districts the decision over the most efficient or effective way to staff these services.

Some of these policy changes arose from proposals which had been aired since well before the 1982 reorganisation. The 10 per cent reduction in the revenue which districts could allocate to management and administrative costs, for instance, was first proposed in 1980 in paragraph 34 of HC(80)8. Proposals to privatise non-medical services were proposed at least as early as July 1980 (Times, 15th July 1980). Nevertheless, measures such as these rankled with some people interviewed because they felt they had been led by government statements to expect that after the 1982 reorganisation they would be entrusted to manage within the finances allocated. As far as they were concerned that was the purpose of the reorganisation and the meaning of statements about devolution and delegation of management responsibility to more local levels.

The announcement of the NHS Management Inquiry was made on 4th February 1983. Only ten months had elapsed since the DHAs were established and this is important in explaining why this measure, on top of all the others listed above, built up resentment and irritation. Central government had insisted that health districts advertise their posts widely. Consequently, many employees had not only to apply for their "own" jobs, but had also to apply for other jobs in case they failed to get the one they wanted. All these applications had then to be considered. The consequence was that many of the key managerial posts took a long time to fill. Many of the Unit Administrators (UAs) and Directors of Nursing Services (DNSs) had not been appointed and the UMTs had not begun to operate before the NHS Management Inquiry was announced. This affected the judgments made by many officers of the Inquiry Team's

proposals. The Chief Nursing Officer (CNO) in Dunhurst expressed this succinctly. She said;

> "I don't think the Griffiths changes are based on any research evidence at all that the 1982 reorganisation was not working."

The point to establish here is that these this interference in the management of districts was consequently resented in a way which coloured subsequent events within the districts surveyed. Other people viewed these things differently and saw them as the accountability necessary for the reorganisation of 1982 to work. As views differed between individuals, so the consensus differed in each of the districts concerned. The consequences of this for the management arrangements and for the success the four districts had in devolving management to units will be seen in the account that follows.

Delegation: responsibility and accountability

Central to the issue of delegation and accountability within districts was the extent to which the nursing budgets could be delegated to the UMTs. This was an issue which was to surface again with the implementation of general management at unit levels, when the Unit General Managers (UGMs) would replace UMTs. Nursing staff salaries make up the biggest single source of health district expenditure. However, what makes the issue of such importance is the history of professional development of nursing over recent years and the extent to which some nurses foresaw that delegation might undermine this progress. A key element in this

professional development had been the increased importance attached to nursing management. The implementation of the Salmon report (Ministry of Health, 1966) and the Mayston report (DHSS, 1969) gave experienced nurses an avenue for promotion into management, which previously had been restricted.

The provisions of the 1982 reorganisation in this respect were ambiguous. Most people understood the reorganisation to be about delegating operational decisions to units but those who wanted to resist this could point to paragraph 27 of Circular HC(80)8 where it said;

> "Authorities should arrange their services into units of management, each with an administrator and a director of nursing services, directly accountable to the district administrator and district nursing officer respectively,...."

On the other hand, in paragraph 29, the Circular urged the "maximum delegation to units of management" and said that there was a need for Authorities to determine "which decisions currently taken at area or district level could be delegated to units". The result of this ambiguity was that the delegation of nursing budgets to units of management might not go ahead smoothly, when many people in the district thought it appropriate.

The anticipation of resistance from the CNO might have been a factor in Dunhurst, for instance, where no decision to delegate was made. In Milham it went ahead, despite considerable resistance from the CNO. In Wimbury, it is arguable that resistance to delegation came from lower down where the DNSs were

unwilling to take responsibility.

In Heathdown, however, the DGM blamed the unit structure itself for lack of progress in delegating nursing budgets. He said that progress in meeting the objectives of the reorganisation since 1982 had gone "Not very far". He said that there was the opportunity to delegate resources and decision-making to the units and "to some extent" this was done. However, he said;

> "there was no release from the unit managers to the department heads. Therefore, it didn't go closer to the bedside than the unit level (which is a long way from the patient bedside). Therefore the idea of having senior managers within hospitals having the ability to vire things didn't take place and you found they had to refer to their UMT."

He admitted;

> "Probably people were a little scared to release power and there is a conflict between the requirement of the Authority to be perfectly sound financially - which requires good/sound financial instructions - and allowing people to get on and do their own thing."

On the other hand, his Deputy claimed there were "very dramatic improvements" in 1982 and could see "no significant changes" by which management could have been improved.

The DT's point of view differed again from that of the DGM's. He may not have shared the same concerns about delegation, and did not express any. Of the district's progress towards the

objectives of the 1982 reorganisation, he said,

> "I think we went some way.... I think the structure we set up was OK."

However, he also said;

> "The difficulty is that we really haven't had time to judge whether the provision of care is better than it was under the old system.... I think the structure was there to enable it to be done. I think if we hadn't had Griffiths and we hadn't had this centralist intervention - then I think we may have [here, he outlined a proposal to divide one unit]. If that had been done, I think the structure would have been very good in terms of meeting the objectives set forth in 1982".

Opinions about nursing management were divided. Some, especially medical representatives, said they had never been impressed with its quality. Heathdown's DT, when asked about nursing management, said;

> "I think its been too sucessful... in involvement, but not very successful necessarily in coming out with the right policies. I think of all the disciplines in the health service, nursing appears to me to be the most poorly managed."

The District Medical Officer (DMO) in Heathdown said;

> "I would have thought the senior nurse managers are probably better and more interested in management and long-term planning [than the doctors]. One or two are quite good at it - there are others who are interested but not terribly good at it."

In Heathdown, unlike the others, the CNO was not available for interview and no claims were made, as they were elsewhere, that nurses were better at management than anyone else in the NHS.

In Milham, the development of good relationships between individual officers on the DMT was difficult from the outset. Nursing management and delegation was thought to lie at the centre of the district's troubles. As Milham's present DA said;

> "Although they're very active and very involved, I think partially because of the way in which the DNO chooses to work, they can block things - much more frequently than anything else. Obviously when a unit is looking at resources and moving resources about and developing services, one of the main things they're looking at are the nursing resources. But the reaction, 99 per cent of the time, they get is 'No, you will not touch that because the DNO says you can't' rather than any coherent argument as to why those resources need to stay with the nursing."

As in Heathdown, most respondents had little difficulty in saying that they thought the purpose of the 1982 reorganisation had been delegation downwards to units of management. However, the commitment of some in favour of delegation appeared to be rather less, and in some cases over certain issues, lacking altogether. The CNO and the DT had been involved in a protracted dispute over where the responsibility for the nursing budget should ultimately lie.

The CNO stated his support for the 1982 reorganisation, rather weakly, and in different terms from the way others would have seen its purpose. He said;

> "The essential reason was that it was felt that the premiss on which the 1974 reorganisation had taken had not been a very good one. The idea was to invert the pyramid - to start with the patient and build it on that."

The CNO obviously felt very happy with the 1982 reorganisation as he understood it. When asked what he thought was wrong with it and what were the reasons for the Griffith changes, he replied;

> "I didn't think there was anything wrong with them. I thought Griffiths was superfluous and unnecessary."

However, nowhere in his approbation of the 1982 arrangements did he support the intention of delegation downwards. Along with the disbanding of the Area Team of Officers and the establishment of more local health authorities, delegation of management tasks down the functional chains had been one of chief proposals made in HC(80)8. In Milham there had been something of a battle to get the CNO to relinquish his control of the nursing budget and delegate it down to the UMTs and DNSs at unit level. At one point, for instance, the chairperson said;

> "We had to devolve budgets down to some sort of unit system. So we first devolved them down to units, against considerable resistence by our nursing officer. I wanted, and the DT wanted, and then the rest of the DMT, wanted to devolve the nursing budgets down to unit level. It took away some of his

hierarchical authority."

If anything, the issue was described more fully by the DT. He said;

"I mounted a very strong lobby, in the face of many of our senior colleagues, for the delegation for as much as we possibly could from district level down to unit level. In particular this involved a great deal of effort to shift the reponsibility for nursing resources away from district to unit level... I think the CNO is somewhat doubtful about the merits of unit management. I believe he has very strong views about unit management and its potential for success.

When asked how this was resolved, the DT replied bluntly;

"By bulldozing it. By lobbying members and chairman and people at unit level and getting such a weight of opinion behind the move that I was finally able, in the beginning of 1984, to get the Authority to accept formal delegation of the nursing budget down to unit level .... Having said that, I don't think the CNO necessarily accepted this had happened. He behaved as if it hadn't happened which created a great deal of tensions within the UMTs between the DNSs and their medical and administrative colleagues."

The ex-DA also referred to this battle. "Eventually" he said;

"the nurses wanted funding for a ward shortfall. We [the DT and himself] said that 'the price of funding your shortfall from our resources is that you'll delegate the budget to the DNSs'. It

sounds Machiavellian but it wasn't. Over time, you work at things and people work at me to change my views and I work to change theirs."

The accounts given by all respondents in Dunhurst agree that the district was unsuccessful in the full delegation of responsibilities down to unit levels. As in Heathdown and Milham, the CNO appeared reluctant to delegate budgetary control to her unit nursing staff, but in Dunhurst the issue was not contended by her because none of the district officers attempted to push delegation down to UMTs. The nursing budget was not delegated down to the unit DNSs, and remained with the CNO at district level until the DGM replaced the DMT. Once the DGM was in post the situation was reversed: "the General Manager", said the DT "is absolutely obsessive that nurses beyond ward sister have no role in management whatsoever." The DMO agreed;

"She [the CNO] feels it is a very strong need for nurse guidance and leadership from the top - to keep standards and to support her nursing staff if they, she feels, are not being considered. He [the DGM] doesn't like that. He is changing it."

Rather than any obstinacy by the CNO, two reasons were put forward by respondents for the district's failure to delegate. On balance, these have to be accepted because the district also failed to delegate operational management of all kinds, not just nursing, down to UMTs. The most common reason was related to the district's poor finances, together with the number of units to be managed. The member interviewed proposed another reason which does not contradict the financial reasons which most respondents

put forward. He explained that quite contrary to the ideas behind the 1974 reorganisation, the district covered areas in two counties with its population split equally between the two. The district then had two levels of staffing in those parts of the service which were previously provided by the local authorities. The district then had to cope with getting the practitioners to realise that their responsibilities were no longer to the county authorities. The district general hospital had opened soon after the 1974 reorganisation but the rest of the district's services were based on very small facilities. Dunhurst had a fast growing population in an area where previously the service had been at a low level. There were, therefore, huge disparities in the size of units that existed both before and after 1982.

The member's view may be correct in explaining why no attempt was made to delegate in Dunhurst, even if it was rooted in 1974. However, it was the spread of the district's finances which usually was regarded as the reason and would, in any case, have helped to perpetuate the situation. According to the DT, the splitting of the district into five units of management meant, in combination with the lack of finances, that;

"it was inevitable that some of these units would be managing relatively small resources. This meant that the professional members of the team would not be of the highest paid and as a result of which, you tend to have, where the management is appropriate to what you're paying but not as good as if we'd had two units."

Chapter Six
Health districts transformed, 1982-1985: delegation

A description of the delegation undertaken in Wimbury is more difficult than in the other districts because, while two units became very powerful - their management functioning very effectively - other units were very weak and ineffective. This is true of both the nursing budgets and the administrative staffing. The two powerful units concerned each had budgets comparable to whole health districts used in this survey.

As in Dunhurst, respondents often referred to finances as a problem. In Wimbury, however, these financial difficulties had a different cause. Formed by the merger of two teaching districts in central London, Wimbury has to reduce its resource base under the RAWP (Resources Allocation Working Party) formula. [This detail is necessary here but will not be published.] It is upon the ability of this district, and others like it, to reduce its spending, that the other districts surveyed depend for any resolution of their financial problems.

Finances, however, had not been the only problem facing Wimbury in 1982. There was the additional problem of the integration of the two previous districts. The CNO spoke of a "natural antipathy" and of the staff holding a distrust of each other. Apparently staff at one end of the district were afraid of having their "centre of excelence" status diluted, while staff at the other were afraid that the reorganisation would be a "takeover" by the prestigious other end. This was a problem which gained additional significance when set against the ambitions shared by senior officers within Wimbury towards involving clinicians in management through clinical budgeting.

Chapter Six
Health districts transformed, 1982-1985: delegation

While the DHA decided upon client-care based units of management for three of its client-groups, it was a structure which was never fully implemented. The Deputy DT, for instance, said;

> "Those Units have never been, as far as finance is concerned, staffed. They've been serviced from the centre. "

It was a situation explained by the Deputy DT as relating to the merger of the two districts. He said;

> "In our case, and only in our case, I think the merger of two districts overnight... was totally unreasonable. Reorganisation could have occurred a year later in our patch because we needed a year to think about it to be frank. We had structures that we couldn't appoint to and yet were being expected to manage. That's how long it takes to interview, appoint, the period when a new person starts, they've got to settle down. We had a single Community Unit from [April 1982], no-one was managing it. ....effectively what we had was the community bits of the two old districts going along without a leader."

The lack of progress in appointing people to the senior management posts was confirmed by the CNO. When asked if she thought that the management arrangements made in the district in 1982 could have been better, she replied;

> "They could have been more speedily implemented which would have enabled us to judge whether they were right. [In December 1984] we still had posts un-filled - we still had the Paediatric/Midwifery Unit non-functioning. No they hadn't been

fully implemented. One reason why they hadn't, to be fair, was this stupid regional round-up of how you could and couldn't apply for posts, and it took forever."

During the period following the establishment of structures in 1982 until the restructuring that Wimbury was planning following its appointment of a DGM, the viability of the other care-group based units was also called into question. Lack of progress in establishing these units was, indeed, the reasoning provided by respondents for the Wimbury's restructuring in 1985. The decision reached in 1982 to establish a Paediatric/Midwifery Unit had never meant very much. In 1985 the unit was abolished, having never been staffed and without opposition from the paediatricians who had previously argued for it.

In general, the difficulty these units encountered was related to the fact that none of them had separate identifiable premises and all were partially operating on sites which were managed and maintained by the two acute units. Independently, two officers cited the case of a patient who had escaped from a secure ward while in the care of the Mental Illness Unit. The patient then met with an accident and the acute unit took responsibility for the patient's care. The accident then proved fatal and a dispute ensued between these two units over whose responsibility the patient's death was. This was on top of a series of minor "problems about whose responsibility was what". The sort of problems encountered were exemplified by the DMO. According to him, one of the acute units would freeze a secretarial post in the Mental Illness Unit's part of the institution because the

secretarial budget was still part of an acute unit's reponsibilities.

These sorts of problem demonstrate that Wimbury had not felt able to delegate management tasks sufficiently, particularly to the smaller client-care based unit.

So, in sum, there were a variety of reasons provided by respondents for the inability of the four districts to delegate. The reluctance of nurses was only one of these, although, as was seen in Milham, it could be overcome. The time lag in appointing unit staff was another cause of delay, particularly in Wimbury. Most long-term delay, however, arose from the structural arrangements made in 1982. This was important in Heathdown, Dunhurst, and Wimbury, and with senior managers in the districts aware that delegation had not been as successful was hoped at the time, the forthcoming implementation of general management was used, quite frequently, as a justification for altering original structures. Too many units meant that management costs had to be spread too thinly for staff to be appointed of sufficient calibre to gain the district staff's confidence. Plans were in hand to reduce the number of units of management in each health district. According to the plans being made at the time of the interviews, the districts planned to alter their unit structures as follows;

	Units after 1982	Units planned 1985
Heathdown	4 (2CC+2NCC)	2 (2NCC)
Milham	5 (2CC+3NCC)	4 (2CC+2NCC)
Dunhurst	5 (2CC+3NCC)	undecided
Wimbury	6 (3CC+3NCC)	3 (1CC+2NCC)
Total	20	--

CC = client-care based units

NCC = non client-care based units

So, if these plans were to be put into effect later, the numbers of client-care based units would be diminished, although in Milham it was a specialty-based unit which was to be amalgamated with another. The existence of these plans might serve to indicate the sort of judgements being made of client-care based units and the radically different management arrangements established in 1982. However, this would involve making comparisons between the 1985 plans and the 1982 proposals put to DHAs before any alterations.

The later stages of reorganisation

The onset of the implementation of general management was an opportunity to restructure management arrangements in each of the four health districts. It also began to affect relationships, particularly at district level. This is because, one of the consequences of the government's launch of an inquiry into the management of the NHS was a far-reaching internal debate about the

respective roles of the DHA and each of its officers. Among the respondents, the inquiry had its supporters, obviously including those who were designated or appointed as DGMs. They, and others, saw the recommendations as essential if the provisions of 1982 were to work. The member in Milham, for instance, said;

> "They want some decent experienced managers in.... If you have a GM, as is intended, and he is a good manager, then he should be capable of saying, and say, 'You will'."

Others did not see the issue so simply, even if they were generally supportive, and others merely wished that the changes being introduced in 1985 had been introduced at the same time as the 1982 changes. However, some respondents expressed considerable opposition to the principle of general management, particulary in Milham and Dunhurst. To understand why the inquiry was so contentious, some preliminary comments on the inquiry and its report have to be made.

Griffiths: the end of the lowest common denominator?

The NHS Management Inquiry team reported its findings in October 1983, a mere 19 months after the establishment of DHAs. Many comments have been made about its findings and recommendations which fall outside the scope of this research (see Petchey, 1986 for an example). The inquiry's significance arose because the team expressed in its report a concern for power and the diffusion of power within the NHS. To put this concern into the report's own terms, the inquiry team directed attention to the inability to

state who was in charge. Its most enduring phrase was;

> "In short if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge."

This concern deserves, and has attracted, considerable comment. As a report intended to persuade the government (if, indeed, the government needed persuading) the strategy of placing Florence Nightingale in their position appears to have been considered as sufficient authority for their stated recommendations and for the key assumption that it matters that everyone knows who is "in charge". To many people interviewed, the inquiry team appeared to have s ught, quite deliberately, to avoid any evidence to the contrary, and indicated some disdain for what it called "the already considerable library of NHS literature" in the report's first sentence. The team made its recommendations for general management without stating that it had given any thought to considering why consensus teams were thought necessary in the first place. They therefore chose to ignore the commitment to management by consensus which had been obtained from many within the service and which was demonstrated by many of the respondents in this survey.

The team's recommendations, once implemented, would alter the management arrangements established in 1982 and yet, as it acknowledged itself (in paragraph 5 of the general comments) many of the unit managers were still being appointed. People interviewed in the four health districts drew from this the inference that any judgement of the reorganisation might have been

premature. Despite this, in the report's next paragraph, the team stated its judgement on the reorganisation. It said;

> "It [the absence of general management] means that the process of devolution of responsibility, including discharging responsibility to the Units, is far too slow."

Later in the same paragraph, it acknowledged that "The Units and Authorities are being swamped with directives" but failed to acknowledge why unit *managers were taking so long to be appointed.*

It is tempting to draw attention here (and many have done) that the team's recommendation of a management principle stemmed from its experience of commercial management without presenting any evidence that commercial management is better. Heathdown's chairperson, for instance, claimed at one point, that "the health service has less administration, I think, than any private industry" refering to recent statistics produced by the National Association of Health Authorities and the Confederation of British Industries. However, the point that really needs to be stressed is that in not outlining in detail the faults of consensus management, it was possible and perhaps only reasonable, that people in the service should read the report as a deliberate attempt to by-pass any evidence that might have suggested that consensus management teams were necessary. The government's adoption of the report's recommendations (DHSS, 1984, paragraphs 4 and 5) ignored the profound effects of telling people in the service to stop what they were doing and to do something else. People detected signs of inconsistency in the government's actions and statements with a result that some found it difficult to

adjust their way of thinking over how decision-making, and other political processes, in the organisation could or should proceed. Between the publication of the report in October 1983 and the government's announcement in June 1984 (Times, 1984) that it was going to implement the report, considerable opposition was reported in the national press. (See, for example, Sunday Times, 1983, and Times 1984a, 1984b, 1984c, and 1984d.) It is clear from this that the government's speech acts in relation to the NHS Management Inquiry were not failing to achieve universal consent.

Some respondents claimed that the 1982 reorganisation never happened in their districts because the publication of the report stopped dead in its tracks the progress districts were making in devolving management responsibility. As will be seen however, and as the Griffith's Inquiry Team were aware, progress in many districts was already faltering. Attempts to build consensus teams that would work well together were thought no longer worth pursuing. Competition between members of the officer team for the general management posts was not a factor. It was merely that the continuation of efforts to create and re-create good working relationships, stopped being made.

The survey demonstrated how the onset of general management began to affect relationships at a senior level within the districts. At district level, the announcement that the government was to implement the Inquiry Team's recommendations focussed attention on the person in post as DA as the most likely future DGM. (In two of the four districts the DA did later become their DGM.)

Chapter Six
Health districts transformed, 1982-1985: delegation

In Heathdown and Wimbury, the DA, as a potential and then as a designated DGM, soon assumed a key and powerful role. In Heathdown, the chairperson said;

> "We'd already decided, two years ago, that the DA would be the chairman of his officers group .... So we'd moved into this relationship that has now been formed under Griffiths."

The DA and the chairperson both saw this later reorganisation as an opportunity to finish what they had attempted to do in 1982. One thing to note about Heathdown is that although early on the chairperson had not played a major role, his position later became much more significant. In 1982, the chairperson had no influence over organisational issues such as unit structures or management arrangements. Since then, he had worked very closely with the DA. The District Medical Officer (DMO), for instance, said "In this District, clearly the running was made by the chairman and the DA". This relationship was a complementary one, not one in which they were both seeking power over each other. The chairperson described his influence at length and demonstrated how he thought it differed from an officer's influence. He said,

> "No way could an officer have done what I did for getting the new hospital being built at A..... I went up to Ministers with plans that I recommended how to quick-build and so on. This enabled Kenneth Clark to transfer five million pounds to this Region to allow it to happen. Now that is the role, if you like, of a chairman - to be able to use his contacts, knowledge and so on, to get things through the bureaucratic civil service, which would never have happened on the normal officer

wavelength. One has got a very difficult tightrope to walk of non-interference in management against policy. And my role is to set policies and tasks and to monitor that these tasks have been undertaken."

Another thing to note about Heathdown is that, perhaps because of the increased prominence of the chairperson, but equally, perhaps because lessons were learned in 1982, the DHA was involved from the start in restructuring the district's units in 1985. As was seen earlier in Chapter Five, the DGM had described Heathdown's 1982 arrangements as "unforgivable". He outlined his reasons for this assessment and so justified the changes being made at the time of the interview. To recapitulate, he had said;

"I think we made a few fudges on accountability.... So I think that would be something I would not feel proud about. But I think in terms of the way the organisation was divided up - it wasn't a bad go at it. The geographical arrangement works here and has proved to be right."

However, this conclusion was reached this time with the involvement of the DHA members. The DHA had set up its own working group to decide what its structure should be. It included members, the DGM, and an outside adviser. This meant that in 1985 the district's decision-making processes were vastly different from what they were in 1982 when the initial proposals had been made by the the chief officers, only to be changed later. By 1985, the DA had become the DGM in Heathdown and substantial changes were being made to the unit structure of the district. The unit structures were being reorganised along the lines that

its DMT had originally suggested in 1982, that is, upon two geographically defined units. In the chairperson's words this was "the completion of the first reorganisation". Restructuring was, therefore, recognised to have been accomplished over several years and not simply by the establishment of the DHA in 1982.

In 1985, apart from the DGM, the district officers were no longer as involved as they had been. From their point of view the main impetus for restructuring came from the DGM and the chairperson, although most respondents found it difficult to say who, of these two, was most influential. Some said they could not say, others said it was principally the chairperson. Nevertheless, perhaps because the DHA was involved in making the proposals, or perhaps because of recent experience, both the chairperson and the DGM were satisfied that there was no "welling-up" of opposition to the proposed structure. The chairperson said that Region had given its approval by telephone and he was now waiting for a formal letter.

Clearly then, the process by which Heathdown's restructuring took place in 1985 was very different from that which had obtained in 1982. The DA and the chairperson had become pre-eminent, and the DHA had also become involved. The role of the other officers on the DMT was reduced, although it must be added that the CNO was on sick leave for over six months in 1985. Their role was obviously affected by the onset of general management simply because, as the DA's leadership was recognised, they were not in the running for DGM. Consensus teams were, at least nominaly, teams of equals. No opposition to the idea of general management was expressed by

any of the respondants in Heathdown, and the change was going smoothly. Indeed, the notion was welcomed as an improvement on the earlier arrangements. There was a continuity between the 1982 reorganisation and the proposed arrangements in 1985 in Heathdown.

The difficult relationships between the district officers in Milham have been described earlier in connection with the district's delegation of the nursing budget. These difficulties were overshadowed, at the time of the interviews, by the onset of changes resulting from the Griffiths inquiry. For one thing, unlike the DAs in Heathdown and Wimbury, the DA who was new and had replaced the district's previous DA was not the automatic choice of the DHA members and chairperson for the post of DGM. As in the other districts surveyed, the appointment of a general manager and the ending of consensus management resulted in a period of assessment when the management arrangements became subject to review. In Milham the outcome of this review in 1985 was that the number of units was reduced, by disbanding the Community Unit, from five to four units. It was argued that if the units responsible for Mental Illness and Mental Handicap services could manage their own community services then, there was no reason why other community services should not be managed by the General Unit. The chief opposition to this came from the CNO who by 1985 had accepted the idea. He did not accept, however, that consensus management should go. Nor did he accept the new management arrangements that were coming into being. He said;

"I don't think the Griffiths thing is a good idea or concept. It is not ideal. It excludes the nurse. Your general managers aren't nurses. There are many things happening that are good. I don't object at all to the idea of decision-making being focussed but I think if you move to a system that removes the good will you may lose something that is hard to measure."

On the other hand, there were those in Milham, notably the chairperson, who welcomed the implementation of the Griffith's recommendations. He voiced the opinion, shared by many other chairpersons he said, that managing by consensús was a system of management by committee of one sort or another and that "there was a lethargy about the whole thing" that needed to be speeded up. "Now," he asked, "how was it speeded up?" and replied "It was speeded up by the chairman of the DHA acting in a managerial and executive capacity. Which is not what they were appointed for." He claimed that while the inquiry had been going on, many chairpersons had thought it would recommend that chairpersons become the equivalent of Managing Directors as well as being chairpersons. As the Griffiths report had said, the only people who were in the position of making definitive decisions quickly were the chairpersons of the Authorities.

This, incidently, was an opinion expressed by the chairperson in Heathdown who had said that, in earlier times, "One had to become virtually quasi-executive to get things done." Nevertheless, unlike in Heathdown where a sense of continuity between the 1982 and 1985 changes were almost universally agreed, opposition to Griffiths was very strongly felt in Milham, particularly by the

CNO, but also by the DMO. Opposition was not total however. Interestingly, the DA, even though he had now to work with a DGM brought in from outside and must, therefore, have been unsure of his future, had some words to say in its favour. He regretted that general management was not introduced at the time of the 1982 reorganisation, and also regretted that "teamwork" and consensus were to be scrapped across the country when, in his view, some districts worked very well with those arrangements. He nevertheless accepted that in other districts compromise was often reached "for the wrong reason". His view was that "across the board solutions" were an unfortunate way for government to impose policies.

In Dunhurst, the relationship between the DHA and its officer team was, from very early on, unusually tense, as compared with the other three health districts. This situation merits particular attention. In the early days, the officers had less appreciation of the value of the DHA. More recently they had then suffered as the DHA cemented a relationship with its incoming DGM that excluded DMT officers from any further role. Dunhurst was similar to Milham in having a DGM brought in from outside the district, leaving the recently appointed DA unsure of his future role there. However, Dunhurst's new DGM, unlike Milham's, had no previous experience of the health service having previously been a director of one of the national banks.

As was indicated in the previous chapter, the most significant thing about the 1982 reorganisation, for the officers in Dunhurst, was that the case for more resources could be put directly to

their RHA. The removal of the AHA - its first hurdle, they had felt - would help. The officers had not anticipated, rightly at first, that the new local DHA might be a hindrance. The district's financial straits had occupied their thinking (and will, therefore, need to be elaborated upon) almost to the exclusion of organisational issues. Respect for their DHA's judgement and influence remained at a low level, at least until the appointment of the DGM. After that, the relationship between the DHA and the new DGM assumed a significance of which they had to take note.

The chairperson had been convinced that he should, with them, regard the district's finances as a priority. After appointing its DMT, the chairperson stated that the next task was "to take in hand the pr blem that the district faced." He said;

> "The population was expanding - over a decade by 100,000 and is still expanding at 1% per annum. Quite obviously resources have not expanded at the same rate - we are an under-funded district in a, so-called, over-funded Region. Quite clearly we had to convince Region of our under-funding and they didn't believe us at first. D..... Hospital (the district general hospital) was built in the sixties, a so-called 'best-buy' hospital, for a population of 170,000 and with a population now of 290,000 we are grossly under-provided in terms of acute facilities.

The district had some success in this campaign, as the RHA allocated an additional 110 beds in its capital building programme.

At one point during the interview, the DT said;

> "You are going to get some very funny interviews from this district because the resource situation is abominable. This is a fast growing population. It also has a very high proportion of socio-economic groups 1, 2 and 3, particularly 1 and 2. [We have] an extremely articulate and vociferous population whose demands for health care are higher than those that would normally be encountered."

Clearly, the DT was the one most concerned with this financial problem. He later admitted "The over-riding problem blankets everything, it becomes obsessional." However, its effects were felt elsewhere.

As mentioned earlier, Dunhurst's poor financial base affected recruitment. The DMO regretted that, as she said;

> "[there had been] a tremendous clear-out of our administrative staff who had really been a very good team.... We were able to offer rather poor grades in comparison to many jobs that were available."

Poor finances also affected what the district could do with the resources it had. Since 1982, a 150-bed chest hospital within the Dunhurst's territory had been bought by the RHA from the London-based hospital that previously operated it. The RHA was intending that the district would be able to do some of its acute psychiatric work there but Dunhurst had 30 chest beds to be moved into their district general hospital and the result was that it "exacerbated our overcrowding".

These factors might all have combined to reduce the real effects on the decision-making and organisational changes made in the period following reorganisation in 1982. Nobody claimed that Dunhurst was a great success in terms of the objectives stated by the government for the reorganisation. The member interviewed, for instance said;

> "They moved in those directions but I don't think they made a very fundamental change probably to any of the actual working patterns and the way people perceived the demands to which they were responding."

The member claimed also that members had wanted to be involved in reaching decisions about the district. "We didn't want," he said, "to be faced with DMT decisions and for them to say 'Please go along with us'. That's an area that isn't resolved even now, it seems to me."

Dunhurst was only able to recruit a replacement for its retired DA in the middle of 1984 and by then the implementation of the Griffiths inquiry meant that the idea of general management was being anticipated. The chairperson said that they had all hoped their new DA would become their DGM, "but there were clear indications that he wouldn't be acceptable to Region and it required Region's blessing before the Minister agreed on this." Far more than was the case in Milham, the coming of general management was seen as incompatible with the spirit of the 1982 reorganisation. Perhaps it was because the DGM came from outside the health service, or perhaps it was because his appointment meant that their favoured candidate did not get the job. However,

the reason most respondents gave was that the DGM took up his responsibilities in ways that officers and clinicians found unacceptable. Nor did he subsequently and rapidly gain credibility: his proposals for restructuring the district's units and management arrangements encountered difficulty from the RHA.

To varying degrees, there was a sense of crisis affecting Dunhurst that pervaded all the interviews. Finances were held to be the root of most of its problems. However, while this financial deprivation is real enough when Dunhurst is compared with other health districts, the district had a series of management problems within its recent history, of which the problems with its new general manager were merely the latest, and which was unwanted and, consequently, resented. Earlier, in 1977, the present CNO had replaced a suspended predecessor. The suspension of other senior nurse managers was also a possibility at that time. Dunhurst's industrial relations record was not a good one, particularly at the mental illness hospital it had inherited outside its territory. Here, catering services had been disrupted each week-end for a period soon after the DHA had taken the hospital over and these problems were continuing. Interviewed in 1985, the chairperson said "The HAS [Hospital Advisory Service] report for C..... Hospital will show a number of glaring inefficiencies and most of these could be answered by financial input."

In the summer of 1985, industrial relations were taking a second place, among some of the senior managers, to the disruptive effects of the DGM's appointment. Nevertheless, restructuring of

units of management were proposed as a result of the widely-felt dissatisfaction with the existing structure. Members of the DMT had reviewed the workings of the district's unit structures established in 1982 and concluded that, because five units meant appointing UMT administrators and nurses at low salary scales to whom the DMT had felt unable to delegate, two units should be established for the future. The DGM, however, was proposing less radical structural alterations than those desired by the DMT. Information about the DGM's proposals was obtained from the chairperson but the DMT was ignorant of them. The DT, for instance, could not comment upon them. He said;

> "The former team has been excluded from what has been [an] almost exclusively member debate."

The future management arrangements planned by the DGM would no longer involve the DMT and its officers. Instead there would be a board which would act in an advisory capacity only. These proposals were not untypical of other arrangements proposed in other health districts but were greatly resented here, particularly by the DMO who was no longer to have a place on a senior management body within the district. She claimed, "Personally it's a disaster for me in my role. .... There seems to be a total lack of understanding of the role of community medicine." She claimed that the Board was also an unacceptable arrangement for the CNO. Of the proposed changes, Dunhurst's CNO said;

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"It was just too similar to the structure which we'd got at the moment, and yet was not addressing the problems. Apart from one change which was to do away with the DMO's post, ... which was perhaps one of our most major objections. We objected to him because we felt it's almost victimisation to change nothing except one person. If he'd changed my role .... I think everyone accepts that the person who is really affected by this is the nurse - our role has got to change ..... very substantially. If it was my role that changed entirely - fair enough - I may not have accepted it and liked it, but that would have been realistic. The DMO is just ...., however!"

The manner in which the 1985 proposals were made demonstrate that the respective role of the DHA and the DMT had changed since 1982, when the DMT was most influential, even if others were involved. In 1985 the group of members responsible for appointing the DGM met with the DHA and proposed a number of options to consider during a special private meeting. This group included the new DGM as well as the chairperson and vice chairperson, the CNO, the consultant representative on the DHA and other DHA members.

The proposals this group made were attributed by senior officers to the new DGM. The changes were not accepted by the senior officers who had lobbied against them, particularly the DMO. They were not entirely acceptable to the DHA but might have been adopted if it were not for their rejection by the RHA which received them at the same time as the DHA. It is possible that the RHA rejected them as a result of the lobbying of the DMO, and this was suggested by the chairperson and one other officer.

According to the CNO, upon the rejection of these proposals, "The Authority members then decided that they would do their own thing but at the same time asked the DGM to re-do his proposals." On this occasion the DGM's second set of proposals were discussed with the DMT three days before it went to the members. It would have been totally rejected by the DMT but the DMT completely failed to influence them at all through the DGM. Since then, the senior officers had attempted to by-pass the DGM and influence the members. The CNO said;

> "I shall never know whether or not they had their own structure to put forward or whether they then drew one up quickly taking into account what we'd said."

Earlier she had said;

> "The Authority will be seen to have been the people who made the decisions and have influenced what is going on in the new structure in our district. Behind that there has been a lot of lobbying from individual DMT members. But it will clearly come out as what the Health Authority wants. It is not what the DMT wants in its entirity. It is not what the DGM wants almost at all. I'm saying it's the DHA who have over-ruled on quite a lot of things that are going forward which the DMT won't go along with entirely, but perhaps will go along with. We haven't won all our points but we've done it round the back door."

The DGM's second set of proposals, made without any consultation, consisted of virtually no change. Two failed attempts to make proposals, free of pitfalls which others were willing to point

out, resulted in the DHA paying attention to the officers whom the DGM was trying to exclude. In the chairperson's words;

> "...it's probably too early to pass objective judgment on him but he lacks the experience of the health service and it's taken him time to get to know it. He's obviously worked very hard to get into the district and get into the service itself but he can't take in the whole ethos of working with people as compared with figures, and it's proving a problem."

The situation in Dunhurst was that both the DMT and the DHA were prepared to by-pass the DGM, at least for the time being, in order to communicate with each other. Ironically, this contrasts with the earlier position in which the DMT attempted, with the members compliance, to keep the DHA out of matters which the DMT considered its alone. In those earlier times, as was shown in the previous chapter, the DMT, according to the officers on it who were still in post in 1985, worked very well together. According to the CNO, however, the DMT worked well together in those earlier times because everything was questioned. She said;

> "I would always maintain that if something went to our DMT and it didn't go though on the first occasion, in eight out of ten times I'd say, it was right that it didn't go though".

In her view there were benefits attached to the need to get consensus and that the "opportunity to discuss something and then go away and re-look at it" was something that would be missed. The general management concept that "a decision must be taken" was not, in her view, necessarily good.

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Great attention has been paid here to describing the problems of Dunhurst and to showing how the district's financial position was, with some justification, being blamed *for the inability* to delegate its decision-making. The contrast between Dunhurst and Wimbury is, however, remarkable because while both districts were facing considerable financial difficulties, the reponses of people in Wimbury did not display the same sense of imminent crisis as was evident in Dunhurst. Nor was there any sense in which general management was seen as inconsistent with the 1982 reorganisation. Instead, the district was implementing it keenly and had, in fact, been quick off the mark in anticipating the need for it. The newly-appointed DA was designated as the district's DGM almost as soon as the government had said it was going to implement the NHS Management Inquiry's recommendations. This keenness was expressed in such statements as that made by the DMO who said "I don't think the 1982 reorganisation solved the problem of who was in charge, if you like, of fairly [a] complex organisation." The DMO, for instance, when asked to comment on the 1982 reorganisation, said "I think the strengths and weaknesses are very much reflected in the changes we have made now." In this belief that general management was consistent and not opposed to, the principles behind the 1982 reorganisation, Wimbury had more in common with Heathdown in 1985 than it had with the other two districts surveyed. In contrast with the situation in Dunhurst, the overall impression given by respondents in Wimbury was that, although the district faced apparently insurmountable problems, there were things management could do and should do about them.

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The district's inability to delegate after 1982 was not thought to be a satisfactory situation by the chief officers. Consequently, there were well-advanced plans for a restructuring in 1985. A key proposal of the restructuring was the reduction of its units to three. This was a plan that originated with the DMT, once the DMT members had got to know each other and once they had experience of the difficulties their smaller client-care based units went through in relation to the larger acute units. What can be made of the fact that, while the DMT was willing to discuss the matter considerably and involved the DHA in its early months, it then failed to staff the units adequately? The officers' decision not to staff these units adequately might appear to be a particularly devious one when set against the earlier decision, reached with the involvement and agreement of the DHA, to establish the three client-care based units. However, the officers' early concern to involve the DHA members in the decision appears genuine, and a more reasonable view would be that the officers agreed to establish these units and only changed their mind about them some time later. For whatever reason, the DHA was prepared to go along with this.

The intention to establish client-care based units certainly was genuinly desired by the DMO and, to a lesser extent, by the CNO. The DMO had a particularly strong desire for these units to be established. When asked what he regarded as most important or essential at the time of the 1982 reorganisation, he said;

> "I was keen to see some care-group based units. There were terribly difficult decisions about how far you could take it. We never seriously contemplated, and I think it was practical, trying to take that approach across the board."

Nevertheless the DMO was going along with the 1985 restructuring in the district and, when asked whether anything could have been better about the 1982 structures, thought; "Obviously yes, because of the way we've gone since." Over the issue of the Paediatric/Midwifery Unit, he thought things had gone wrong from the instant it was set up. He said;

> "It never worked. ...it was never properly administratively resourced. There was never a proper administrator for it, and so, things could have been better if that hadn't been like that."

He was, however, prepared to accept what he called "the limitations of structures". He said;

> "They don't seem to mean anything to anyone working in the service actually looking after patients."

The CNO was much less willing to accept that things were wrong in 1982, saying she was not in favour of the changes to the unit structure being proposed in 1985. Although not a party to the earlier decision to establish the client-care based units, she considered it the most important issue. She said;

"It means that people with an in-depth knowledge about the care, and what we need to provide that care, are actually going to make the decision about how that care is delivered. Whereas, when you don't have client-care based units - you have problems of, lets say, the General Manager on the Acute site saying 'God, we've got this enormous overspending, everybody's got to cut their budget by x per cent' and at a time when we actually have insufficient midwives, that's not on. We need someone who is actually able to argue that corner."

In her view the proposal would take the district further away from the principles of "Patients first", and it was apt, she said, that the new units were to be labelled "Units of management" instead of "Client-care based Units".

Most respondents voiced the opinion that the small client-care based units had not really meant very much because they were responsible only for medical and nursing staff and planning within their unit, and that many of their wards occupied bits of other institutions.

Another reason for restructuring was given by the CNO who thought that the change to three units, based upon the two existing acute units, which would absorb the one specialty-based unit, and the merger of the other three smaller client-care based units, would ensure that the UGM of the merged unit would have an equal status to the other UGMs and, therefore, an equal voice.

The relationship between officers and the DHA members in Wimbury, became correspondingly less and less significant to the district's organisation and decision-taking. It started out well enough but since then the officers' respect for its DHA members, and the role attributed to the DHA, had markedly diminished. One officer, for instance, said;

> "The sight of semi-democracy in action has not always been a very impressive sight."

The view expressed by the Deputy DT was that he did not "...go along with the idea of having a Health Authority.... I think we could do away with them." His view was that the role of the Community Health Council (CHC) could be expanded, and that the DGM should be left alone to manage. He added to this "I can't honestly see why we need to have Health Authorities, particularly when some of the membership is made up of doctors who work within the Health Authority." These views were not shared by all respondents. The CNO, for instance, had a considerable amount to say on the subject, and it was not as derisory. For instance, she said;

> "I think they have a role of overall coordination... a sort of restraining influence on the more enthusiastic fanatic proponents of particular specialties or areas of activity. And certainly a proportion of them, not being health care professionals, bring in knowledge/expertise from outside the NHS. ...This Authority is unique in my experience in the knowledge they have about what they're doing and their desire to tell us what to do. That's slightly overstating it, to control,

to manage. We've got very knowledgable people, particularly on the financial side and on general management. This has led them to really want to get down to nitty-gritty detail which I have felt was a bit inappropriate."

The DMO, however, responded to a question about their future role in a way that, while contradicting the CNO's view, demonstrates their common concern about the DHA's behaviour and the extent of members' involvement. He said;

"... we've been very successful at encouraging or constraining, or whatever verb you use, our members in a strategic role about priorities and that sort of decision-taking. And in not getting them involved in management. ...Ours are pretty good like that, they don't get involved in a lot of detail."

These responses taken together demonstrate a shared feeling that the role of the DHA was to be limited to priorities and overall objectives and that too close a concern with management was to be resisted. Where the lines were to be drawn around the DHA members' evident interest in these matters was an issue about which the officers' views clearly differed.

The DHA's influence on reorganisation in 1985 was minimal. Asked who was influential in this, the Deputy DT replied, "Obviously the new DGM, his colleagues on the shadow management board, effectively the old DMT, and again, a small group of members." The Deputy UA, who was interviewed in place of the DGM because of her work on the 1982 unit structures and management arrangements, said that the DGM had the most influence together with his senior unit

administration staff. "The other key personnel," she said;

> "was probably the clinician [mentioned earlier] who sees it as a chance to restructure radically and involve doctors. ....In terms of our feeling that we want to restructure down to clinical level and involve doctors, the influence of this particular clinician and several others, that he's brought along in tow, has been paramount."

This view was largely supported by the CNO. She, however, attributed major influence to the clinicians. Again she named the particular clinician concered. She said that he and several other doctors had "enthused our ex-chairman and the DMT". In this, the people concerned were responding with answers that related most strongly to the new management arrangements and clinical budgeting that were being implemented.

This observation leads to the key point about the reorganisation in this district. The involvement of clinicians in management had come to be perceived as necessary, much more so than the introduction of general management principles. Some digression into the issue of clinical budgeting is necessary, therefore, before turning to the attempt to draw conclusions about the reorganisation in the four districts.

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Developing clinical involvement

Plans for the involvement of clinicians in management were unusually well advanced in Wimbury. At the root of this development was the RAWP target which meant that the district needed to reduce its expenditure over the next decade by 10 million pounds. The district contained two teaching hospitals (of which one was reputed to be an international centre of excellence) and some of the clinicians wanted to be involved in how reductions were to be made. So, unlike Dunhurst, a sufficient number of clinicians in Wimbury had begun to see that clinical budgeting could help them because it would enable them to identify, for the first time, what each operation or procedure cost.

The merger of two health districts to form Wimbury had resulted in, according to the CNO and the DMO, the reduction in power of the clinicians. According to the DMO, the distrust of clinicians had "disrupted the established power lines" and consequently the district had run "with fantastically small amounts of medical involvement."

Since then things had changed, and during the interview, the DMO had later said;

> "What we've done over the last fifteen months is very deliberately introduce a new management structure, as part of Griffiths, that is involving doctors to an extent that I would fairly confidently guess is greater than any other in the country."

The details of these arrangements cannot be made too specific here because they have been extensively reported in the health service literature and this would make Wimbury too easily identifiable. The CNO described the extent of medical involvement by saying;

> "I guess there is probably a significant area of apathy, but we've also got enthusiasts and at the moment they seem to be carrying the apathetic. I think we've made enormous strides."

The involvement of clinicians at DHA and DMT levels can be taken for granted in most districts. Here in Wimbury, however, is an example of a plan to secure their involvement throughout the organisation in its decision-making. The plan has been fundamental to the restructuring that the district was implementing in 1985 (and which had been planned for some time).

Many health districts have begun to experiment with clinical budgeting. To different extents, three of the four districts used in this survey have begun to think about how it could be arranged. Again, a contrast with Dunhurst and its response on this issue is instructive. In Dunhurst the idea had been dismissed. While talking about Dunhurst's financial problems, the DT explained how they had affected other areas of the district's work where there might have been developments. The DT said "The chance of it [clinical budgeting] being done at the moment is nil." He explained;

> "Some of them [the doctors] think it might be worth a whirl, but it comes back to resources. [They read] about PACTS and all the other bright stuff... and ask 'How the hell do we work it

here?' and I have a certan sympathy. Look, I think if you're going to give people some opportunity to manage - there's got to be some opportunity to make changes. Opportunities to make changes needs, in crude terms, some sort of seed corn. This works right through this district, we have been baling out with a bucket a little boat with holes in it. And that's what we've been doing for the last decade."

In sum, Wimbury stands out as a district in which delegation to units did not matter as much as its own alternative plan to have real medical involvement in management. It is remarkable that the officer team were able to agree with their DHA members a unit structure that they then felt able to by-pass. Their success in this must be due, in part at least, to the influence of certain clinicians within the district. Matched against them, however, was a recognition that clinical involvement was necessary if the district was to make a determined effort to reduce its expenditure. No such recognition was apparent in Dunhurst: there the financial problem, while still amounting to real cuts, stemmed from the district's inability to attract resources to meet increases in the demands being made. It was a problem from which clinicians, for one reason or another, were prepared disengage. The officers had compounded their problems when, in 1982, they had decided to retain the existing unit structure intact, a decision which had left them unable to attract suitably competent managers, especially at unit level. They then felt unable to delegate operational management. This decision, as well as the rift that had been allowed to develop between the DMT and the DHA members, closed off from them any real support in their decision-making.

The appointment of a DGM in which none of them felt able to place much trust was bound to disturb the district's management further. The view shared by people in Dunhurst, that finances were responsible for the district's problems, cannot be taken at its face value. The contrast with Wimbury suggests that Dunhurst's financial problems, however real they were, continued to be a source of excuses for a difficult management history.

Both these two districts had financial crises as the backdrop against which to develop the delegation of management responsibility. While the account given here has concentrated, perhaps unevenly, on these two districts, it has demonstrated how the activities of central government resulted in widely different effects on their respective reorganisation careers. Leaving aside any local differences between these districts, or indeed between these districts and others in other parts of the country, this discussion has shown how the same national policy environment may, in one place, provoke the radical thinking on management that the government has used on occasions to justify its proposals: whereas in another, management may flounder and the opposite holds true.

Preparing for further change

Leaving aside the direct effects on districts and professions of each government measure, the string of new central government initiatives - and especially the NHS Management Inquiry - had one overall effect. This was a period of intense debate which followed the formal hand-over of authority to the new DHAs.

people were forced to question their roles, and the role of others, within each health district. The survey was conducted at a time when these issues had begun to be resolved with the appointment of the new DGMs. The divisions caused by these arguments were obvious to those involved but what was perhaps less visible was the power struggle between different sectors of the bureaucracy. It was a struggle in which medical interest continued to be minimal.

While some health districts and some professional groups have interpreted general management as going against the ethos of delegation which they had interpreted as central to the 1982 reorganisation, there were others who saw the two reorganisations as closely related. Indeed, as was seen in the quotations above, some regrets were expressed that the two reorganisations occurred as two separate events. So, with the notable exception of Dunhurst, the principle of general management had, by the time the interviews were taking place, come to be accepted either as a viable alternative to consensus management teams, or as unfortunately inevitable. This acceptance is probably the most remarkable thing about the whole transformation of the districts since 1982. Although the idea has had a long history, general managers (or chief executives) with responsibility being vested in a single identified person, had been rejected by governments as unworkable as recently as 1979, in "Patients first" (DHSS, 1979). By 1985, however, local uncertainties about the future role of the chair, the officers, and the DHA had been clarified during the planning for restructuring of management. The DMTs were being replaced by boards of management with varying compositions. The

cohesiveness of the officer group was largely broken and the DMOs and the CNOs, no longer part of a DMT, were being given new roles with new job titles. Prominance was being expected of the new DGMs, even if people were sometimes disappointed by what this meant!

Re-assessment of roles: nursing

The ambiguity over nursing line-management established in HC(80)8 would end with the introduction of general management. Some senior nurses had used this ambiguity to resist delegation after 1982 and the onset of general management was consequently regarded negatively by these interviewees. The previous chapter demonstrated the value senior nurses had placed on consensus management. The CNO in Milham, for instance, had considered the inquiry and general management to be "superfluous". (In Milham, not surprisingly - given the past battles with the DNO - the breakup of the nursing hierarchy was anticipated with favour by the other officers.) Only the CNO in Wimbury said anything good about general management;

> "I think that the Griffiths inquiry was based on pre-1982 perceptions, conceptions, knowledge, and experience. Having said that, I think it correctly identified that the people who make the decisions..., which actually spend the money, are the doctors."

Also, the CNO in Wimbury was one of the respondents who expressed the view that consensus management could work well but could also "end up with a lowest common denominator decision". She also expressed the view that, as a first impression, nurses "are being listened to more carefully since Griffiths!" but thought this was because the district had a DGM who "knows he has to carry people with him - he makes sure he listens to each individual."

In most districts, a harmful effect on nurse involvement in management was anticipated. The DGM in Heathdown, for instance, said;

> "We will have a nursing advisor at district level but their job is advice, not managing.... I think everyone understands what a ward sister does, and what the senior nurse in the unit will do, but between that - I think we'll have to look very carefully...."

It should be noted that the nursing profession's almost universal unhappiness with the general management proposals, at national level, is possibly the most visible conflict in the NHS since the 1982 pay dispute.

Re-assessment of roles: medical representatives

The response of the medical representatives towards the anticipated changes stands in marked contrast to the gloomy forecasts of the nurses. Management, however defined, was perceived as the key to professional status by the nurses - the opposite of how it was seen by clinicians. The impact of change

associated with general management has been described in Wimbury where clinical involvement in management was being developed. Although the consultant representative here admitted to "reservations about whether really you can take Sainsbury's/Marks and Spencer ethos and transfer it to health service delivery.", he also said;

> "I never saw it as a threat to medical staff in the way that some doctors did - the BMA tended to at first.... We're simply not going to be pushed into things unless it's either inevitable or we agree with them. The DGM could only govern by consent."

And so, he thought the principle of general management would be useful. He said;

> "He [the DA, now the DGM] must have been the person most effective. Most of the ideas about administration - he's generated, persuaded others to go along with. He's got a tricky job because he's got to persuade a very strange DHA."

Medical representatives in the other districts regarded general management as advantageous for them. However, most displayed a detachment from the issue. The GP in Milham's response was fairly typical. He said;

> "Whether, in fact, having a single person responsible for making ...[a] decision, will make any difference at all, I doubt it. But that ...[is] the theoretical idea of it."

Others, particularly the consultants, were more positive. In Milham, for instance, the chairperson of the Hospital Medical Executive Committee said;

> "Doctors now have a person to go to rather than a committee.... We've got a DGM you can write to, you write to him and he takes it to a committee, but at least you know you've got someone you can relate to."

This, however, was not seen by the consultant representative on the DMT in Dunhurst where a crisis appeared to be round every corner. He said;

> "I can understand the Griffiths changes being necessary - to try and make things happen. But the Griffiths decisions are being made against a background that is very peculiar to the times we live in. It's one thing to try and make things happen and another thing trying to make things happen in a contracting situation.... Tougher decisions are having to be made and with administrators and general managers coming in who don't necessarily understand - or have the background of how things have worked over the years. They are trying to impose their decisions on work-force who feel they know better - know the system better - and it's becoming very unpleasant."

The involvement of clinicians in management was, however, one of the specific recommendations of the NHS Management Inquiry. This is why it is not possible to describe it separately as was done in the description of the earlier stages of the 1982 reorganisation in the previous chapter.

Like the principle of general management, clinical involvement in management was anticipated, even if it had not yet been worked out in such detail in the other three districts as it had in Wimbury. People in Milham, for example, had learned that their district was to be used as a pilot district for a feasibility study of clinical budgeting, but the clinicians had yet to be convinced of its value.

Respondents were asked specifically to comment on the issue of clinical involvement and this has been described in the previous chapter. They were also asked to comment on whether they thought the principle of general management would give them cause to alter their assessment. Generally, in the non-teaching districts, respondents did not see any reason in 1985 to change their assessment that medical people are not interested in any managerial involvement.

Comments on this issue were often restricted to expressions of the need to gain medical interest. The DGM in Heathdown, for instance, expressed the hope that they could make "decision-making for consultants perhaps more interesting". He also hoped that they would become "more enthusiastic and will see, I hope, also the problems in deciding priorities". His biggest source of hope was the idea of management budgeting where "they'll be enmeshed totally in the system. They'll be a fundamental part of it". However, progress towards this in Heathdown had not even advanced as far as it had in Milham.

Re-assessment of roles: DHAs

The last concern to be considered here is the anticipation of the DHAs' future role. Their importance while the DGMs were being appointed was not disputed. They, and particularly the chairperson, were important in the two health districts where the DA was appointed to this post. They played an active role in Dunhurst in attempting, albeit unsuccessfully, in negotiating with the RHA and the Ministry, to have their DA made the DGM. Their importance in approving and designing the district's reorganised unit structure and its management board was also not in dispute, except in Wimbury. The uncertainty was over their future role. The DGM in Heathdown, for instance, said;

> "I think a lot of people think they haven't got a role but certainly I think they do. One of their significant roles in this districts, because we're going to have two geographical units, is to cut across the management barriers (if I can call them that) and look at the district on a care-group basis."

However, this opinion was a minority one among respondents in Heathdown, albeit one shared by the chairpersons and members interviewed. Most respondents were clearly unsure what the present role of DHAs was, and what it had been earlier. For people who were unsure of their roles, it was anticipated that general management would further reduce the importance of DHAs. In districts where the value of the DHA was already questioned, some respondents expressed the view that general management would make DHAs redundant. Dunhurst's DMO, for example, said;

"I'm not sure that I agree that there's a need for a DHA and a CHC - but they do have separate roles. At the end of the day this is a public service... Because of that I think there should be a monitoring body that is drawn from the public.... They will still need expert guidance on which policies will, in fact, really meet the needs of the population. So it isn't just what the papers are crying out for."

Another example of this kind of comment came from the Deputy DT in Wimbury. His view was that the CHC's role could be expanded, *and* that the DGM should be left alone to manage. He said;

"I (do not) go along with the idea of having a Health Authority.... I think we could do away with them....I can't honestly see why we need to have Health Authorities, particularly when some of the membership is made up of doctors who work within the Health Authority."

Most respondents were not as negative. More usual was the opinion expressed by the DMO in Heathdown. Of the effect of general management on the DHA, he said;

"I don't see that it will alter it fundamentally."

But had earlier said;

"The members haven't always been terribly well-versed in what they ought to be doing"

Speculation about the future role of the DHAs is outside the scope of this study, as is the fact that the chairperson's "quasi-executive" function was possibly anticipated as being no longer as essential once DGMs were in post. The point is that there existed, once the NHS Management Inquiry's recommendations had been accepted by the government, an uncertainty about their future role: and this shows how much their authority was undermined during the period of transformation being described.

Shifting sources of power in the NHS: 1982-1985

To conclude Chapters Five and Six, it should be noted that during the period 1982 - 1985 there were at least four shifts in respect of who had effective power and authority in each of the four surveyed districts.

The fifth chapter showed that the effect of establishing new health districts was initially to concentrate power in DHA hands. This was the first shift. The brief period in which the new authorities were dominant ended with the confirmation of officer appointments (the second shift). A longer period followed during which the district officers effectively took command. They individually had more experience and knowledge. As a team they began to function effectively by consensus, excluding the medical representatives and the DHA from any active initiating role. Gradually another shift in effective power developed in which the chairperson was able to assume a stronger role than any DHA members and to be considered as a member of the DMT. This meant, in much of its business, the chairperson's opinion was sought as a

representative of the DMT. Later, as the DA assumed prominence in some districts (notably Heathdown and Wimbury in this survey) the relationship between the DA and the chairperson grew stronger and stronger, the nearer districts came to appointing DGMs. This could be identified as a shift in only some districts - two of the four surveyed for this investigation. The final shift occurred in all the districts as the DGM was designated. This was occuring during the closing stages of the period covered by this survey, and the result was that officers on the DMT lost much of their previous function. This particularly affected the nursing profession as Chief Nursing Officers lost their veto and at the same time lost any direct line-management responsibilities for nursing staff and for standards of nursing care. Nursing interests were excluded from influential decision-making arenas to an even greater degree than medical opinion since the implementation of general management. The people taking the dynamic role were the designated DGMs, although - at least during the initial part of this period - finding it necessary to refer ideas to the DHA, particularly the chairperson, for approval. So, once again the DHA had a powerful role, with the noted exception of the DHA in Wimbury.

Before going on to the concluding chapter, it is appropriate to comment on the effect these shifts had upon the health districts surveyed. Chapters Five and Six demonstrated that, contrary to early opinion, the spirit of delegation and devolution of responsibility assumed to be implicit in the 1982 reorganisation was not negated by the Griffiths inquiry and general management. Instead, these things, and others concerned with accountability,

might well have been planned by central government in tandem with the 1982 reorganisation. Several respondents said that if it general management was not planned along with the 1982 reorganisation then it should have been.

However, in retrospect it is clear that a government intent upon the devolution of authority to smaller bodies would only have caused great disjunction if the officers had been made powerless at the same time. Somebody with experience had to be there until DHA members gained experience and knowledge. The establishment of smaller health authorities in 1982 with, for a while, fewer experienced members was an effective strategy in encouraging administrators to accept a right to manage. They began to accept that the necessity for deciding priorities was only their responsibility. This became part of the thinking of administrators. The effect of this was to reduce the involvement of medical staff who previously regarded the voicing of their interests as legitimate - and therefore as a legitimate way of influencing decisions and so of deciding priorities. Once this legitimacy was lost, the changes could be both reinforced and accepted more widely by selecting and renaming some administrators as managers.

While recognising that many changes needed to be made and that the government adopted an effective strategy for change, there are, nevertheless, criticisms to be made about the strategy. Power, responsibility, and authority were continually on the move during this period and the NHS Management Inquiry was unfair to criticise the NHS for delays in delegation to units while this happened.

Small wonder that the Inquiry Team found people were unsure about who was in charge!

Chapter Seven
Power in the NHS: 1982 - 1985

Introduction

The conceptual and research problems associated with investigating power within the health service have so far been presented separately from the empirical observations. Despite this presentation, the decision to make organisational change the focus for a study of power, the particular research questions, the conduct of the interviews, and the interpretations offered were all illuminated by the development of the conceptual and theoretical aspects of power presented initially in the earlier chapters. These theoretical aspects of power were continually being developed while the empirical investigations were planned and conducted, and were reviewed as the empirical evidence was interpreted. This concluding chapter is intended to link explicitly the theoretical and the empirical and to act as a bridge between the various elements of the study. The intention of the research was not to arrive at any new or definitive concept of power, nor was it intended to test any particular theory against empirical observations. Instead, the ideas of Lukes, Hindess, Edelman, and Foucault were judged relevant for the reasons outlined on pp26-43 and it was intended to see what their theoretical frameworks could bring to an understanding of what was going on in the National Health Service (NHS). This is to reject the view that the operation of power should be conceived, as it often has been, as the working out of conflicts over interests.

The relationship between observed activity and political intent must remain uncertain and this is complicated by the fact that while the administration/management and the medical professionals

were engaged in observable political activities, they may also have been acting in ways which were unseen. After the discussion on power in Chapter One (ppl-60), it would be wrong to limit the analysis of the empirical evidence of political process as merely a war between two or more factions fighting to protect or to obtain decisions in reference to their interests. While this was real enough, particularly to those taking part and so may have been used to explain their own actions, the people observed may also have been acting in reference to some form of professional or medical knowledge. Equally, beliefs about the political process and influence of others in the NHS may have informed their acts and their explanations for what was going on.

This concluding chapter begins with a section which examines the internal p wer relations of health districts during the period they were being investigated. Then an attempt to make more general statements about power is made in an intervening linking section which widens the initial examination of power within health districts to consider the actions of government on health districts. This intervening section examines how far it is fair to say that the NHS was transformed by the government over the period. The government was the most visible influence for change. However, the impetus for change may have come from elsewhere and there is no reason to exclude the possibility that the government acted after it had accepted, in some form, a body of knowledge which it saw as legitimate. Indeed, this is the main contention of this section and it is perfectly in accord with this to observe switches in policy within a broadly consistent legal and/or managerial knowledge base which itself was always open to revision

and constantly being redefined. This, of course, is to say something about political strategies and intentions. Together, the first and second sections form a re-examination of the processes observed to see what, if anything, they say about aspects of power within the NHS. Because the second section is an attempt at taking a wider look at the operation of power, it is appropriate to be clear about how far it is justified to generalise from this investigation. So this section introduces the problems of extending from the specific observations made in this study into a wider context. Finally, this qualification to the claims which are made (and others) are addressed in the final section which reflects upon the research strategies and methods used in this study to explore their limitations.

Power relations within health districts 1982-85

The 1982 NHS re-organisation itself, as well as many specific measures which followed, ensured that government was a continual influence on health districts. Moreover, the government articulated a discourse (Foucault, 1972) which fostered a particular political climate in which the health service had to operate. That is to say, government expressed the desire to achieve value for money ("the Government had to ensure that every penny went into patient care", Norman Fowler, quoted at the Conservative Party conference in 1982, The Times, 4th October, 1982) on behalf of taxpayers. To ignore this influence on health districts and within them would be foolhardy. People within the service knew that this was how they were to be judged. Moreover,

the implementation of annual reviews and the necessity to make appointments in which the government would also take a censorous curiosity ensured that people knew they would be judged and held to account. The strength of the government's position in relation to the health districts was not simply guaranteed by its structural and legal authority. Nor did it come about because the government controlled the flow of finance. Its strength also derived from the fact that the discourse it was articulating was thoroughly reasonable (an appeal to rationality). That is not to say that there were no alternatives - the medical professions have for years been articulating the view that only they were qualified to judge medical success and failure - and what the government was saying was bound to be re-interpreted in the light of these. The discourse would then be separated from its original source and perhaps transformed in its reinterpretation or when intertwined with other discourses. So, the political climate was likely to be modified by the people within the health districts and affected by their relationships and this makes it important to understand how these worked at district level. Before describing this it is worth noting that the government's strategy was as likely to be characterised by discontinuity and limitations as by predetermination. Comprised of experienced politicians, advised by its civil service, it is probable that the government had a fairly accurate picture of health service people and their relationships when it designed its strategies (long or short-term).

Chapter Seven
Power in the NHS: 1982 - 1985

The association between unity and political strength would probably not be thought novel to any practising politician but appears to have escaped the political theoreticians reviewed between pp25-43. However, it may well have been a factor in the day-to-day operation of power. It may have influenced working political practices and may have formed the basis of internal political objectives. At points during this investigation, the unity or cohesion between people was clearly of importance. For instance, it lay behind many of the proposals and counter-proposals put forward for the units of management and management arrangements (pp176-204). Specifically, the unity of influential *clinicians was suggested* as an explanation for the DMTs in teaching districts proposing minimal change (pp192-3); the unity of DMTs was a factor in their increased influence at the early stages of restructuring (p293-95); and disunity was said to be cause of reduced medical involvement for a two-year period in Wimbury (p355).

The structural arrangements introduced by the government during the period led to an obvious necessity for people within the health districts to make decisions. So it was at this level that power was most visible but this was where it was at some distance from the government's own initiating actions. Decisions over the re-structuring of the NHS and organising units of management, the allocation of budgets to various sectors, the delegation of control and responsibility, and the representation of medical interests were all visible aspects of power which corresponded to the first and second dimensions of power as outlined on pp24-26. However, efforts to influence internal decisions - such as

delegation of nursing budgets (pp316-19), or type of units of management (pp227-37) - had both an immediate and particular effect and effects which were more widespread. An immediate effect was that control of nursing and the resources to be allocated to various sectors such as general surgery were the direct outcomes of these decisions.

A more widespread effect of the making of structural decisions was to make the administrators, and briefly the District Health Authorities (DHAs), more powerful in relation to the doctors (pp367-68). A decision-making analysis of power demonstrates that the ability of doctors to take part in these decisions diminished because sufficient numbers were not willing to be involved (pp295-310). It is possible that doctors were sophisticated enough not to be concerned about these issues because they thought that they had a power which was independent of who formally took decisions. Historical experience or an assessment of the personalities of the administrators may have combined to make them willing to gamble that their power would soon reassert itself. However, their uniform response during interviews revealed that their judgement was based on a decision-making and structural conception of organisational politics and a faith in individual leadership or representation within these structural mechanisms. Their error was in thinking that their involvement was unnecessary because they thought their interests would be protected at a higher level in the decision-making structures of the health districts, the Regional Health Authorities (RHAs) and the NHS. In this, their judgement appears to have been mistaken because before the power inherent in the representation of medical interests

could be re-asserted, administrators had began to take on new roles (p284). As was seen in the health districts studied, doctors assumed that the continued existence of medical representatives in the bureaucratic hierarchy would be sufficient to guarantee an influence. Instead the District Management Teams (DMTs) because of their relative experience, knowledge, and cohesiveness as consensus teams soon gained the reputation for being powerful (pp285-95). The government's activities (pp312-16) were crucial in forcing administrators to be continually active but, the mistaken judgement of the medical professionals was a contributory factor.

Medical reluctance to be involved with administration or management arose possibly because, as some claimed (pp303-04), these tasks and roles were not part of their expensive training. In other words, these were not part of medical knowledge. Medical ethics with its concern for the individual patient (as well as the availability of private practice) reinforced this view. Collectively these factors disqualified and disabled them from taking a managerial role. They merely relied on their individual interests, or those of their specialty, being represented by individuals at different places in what they saw as an administrative hierarchy. During this period, they were apathetic and predisposed to thinking that the veto power of the representatives was sufficient to safeguard their interests (pp296-300).

Chapter Seven
Power in the NHS: 1982 - 1985

By the end of the period covered by this study, people who might formerly have regarded themselves as administrators were beginning to regard themselves as the managers of their health districts. (Often they were the very same people.) At first, in the absence of experienced and knowledgeable health authority members, it was the consensus teams which took on a specifically managerial role. Doctors found that their influence at unit level could be overruled by a higher officer body where their representatives felt hampered for a variety of reasons detailed on pp297-306 and that, further up the hierarchy, their influence over DHAs was minimal. The implication of the government's introduction of units of management was that sectors of the service (corresponding to units) could be expanded or contracted by a body of officers who had influence over their DHA. Later, when the Griffiths report had been published, this managerial role began to be individualised. (Heathdown's Chairperson, for instance, spoke of the decision two years earlier to give the DA the chair of his officers group, p134.)

Organisational restructuring might have had implications for health districts' future budget allocations and so affect doctors directly. But the government could rely on medical indifference to administration and to managerial matters and so placed the responsibility for organisational restructuring on the DHAs. The process allowed very little participation (pp209-12) and that which did occur must be regarded as largely symbolic. This will be discussed further into this section but, for now, it is important to examine the impact of making structural alterations. The government was able to rely on DHAs being influenced by

district officers. In time, district officers gained the reputation for concern with and influence over the shaping and funding allocations internal to the new health districts. Much later on during the period, when the government's acceptence of the NHS Management Inquiry team's proposals were announced, and it was known that consensus management teams were soon to be replaced by designated general managers, it became progressively harder for administrators - other than designated District General Managers (DGMs) - to obtain approval for organisational and structural proposals from their DHAs and chairpersons (pp329-60).

It was this long-term process where officers, then DAs, and then DGMs, increasingly became the focus of district organisational activity and so gained reputations for influence that ensured a changed perception of their role. There is no evidence to suggest that this increasing reputation actually allowed them greater influence (although that is not to deny that it occurred), but it did enable the government to introduce the concept of general management and to promote officers to these positions without encountering any overwhelming objections or effective resistence from the medical professions (or anyone else). So organisational restructuring was a crucial element in transforming the NHS and the government's influence here is obvious. But so too is the fact that in interpreting the organisational and political environment in which they worked, people made judgements and decided upon actions on the basis, perhaps only loosely, of their own views on the operation of power. There were two widely different views expressed during interview. A common belief in the innateness of good leadership as a personality trait was one,

the other was a belief that structures were important. Both were widely expressed but their truthfulness must be doubted.

The power to take decisions or make policy is the one dimension of power which was readily recognised by people in the organisation. For this reason, but only for this reason, people's reputation as powerful or influential was important. The same applies to the structure of decision-making. During interview, most responses concerned this kind of power. Respondents differed over their explanations, however, either indicating that personality and reputation granted an individual or group their power or that structures allowed various people or groups to influence decisions.

The notion of power as a personal attribute was particularly current among medical people (p300). Indeed, their reliance on representatives was shown to be a factor in the decline of their influence. Doctors were quite mistaken in their belief that certain individuals among them were powerful enough to act as their representatives. Again, they were mistaken in thinking that they were dealing with a hierarchical bureaucracy with the DHA at the top. Relying on their representatives, they were not interested in playing much of a part in the bureaucracy, and so ignored the possibilities which they might have created for influencing the way people thought roles should be developed.

So, while some thought that personalities were more important than structures and that goodwill between people was necessary for any structure to work, some put a great amount persuasive effort into structures. Notably those with reputations for being powerful, so

they at least must have thought them important (the DA in Heathdown, for instance, pp262).

In Chapter Four as well as in the professional literature reviewed earlier, it was argued that the establishment of unit structures, in terms of how many units and the basis on which units should be formed, might reflect the importance attached by various actors to specific focii of activity. The integration of hospital-based services with community services for specific client-care groups might also reflect the continuing commitment and loyalty to the ideal of a fully integrated and co-ordinated service which was so disappointed after the 1974 reorganisation. Later in the period, some districts were reorganising their unit structures again. Issues f management arrangements, division of responsibility, and appropriate accountability remained important, but the early influence f the new DHA members on the creation of unit structures with client-cared based units had waned.

So, dichotomous beliefs about the possibilities for structures to channel power and for people to provide leadership were expressed. Nonetheless, it is possible to draw these together in a way which makes it possible to explain how both views were credible.

To do this, it is necessary to move away from the first and second dimensions of power as outlined on pp24-26. Lukes would argue that both notions of power were misconceived (which may be true) and that this misconception resulted from the actions of others. However, both the second dimension of power, the ability to keep things off the political agenda, and Lukes' third dimension are less than easy to observe empirically. The operation of the

second dimension of power depends on organisational culture and unwritten rules. The issues which remain off the agenda also remain unobserved. The ability to keep things on the agenda, to insist that decisions are reached over certain issues, and the ability to frame decision-taking agendas in certain ways are much more visible. Further difficulty is encountered when trying to observe Lukes's third dimension of power, for it is the manipulation of thought so that people either remain unaware of their interests or misconceive them. As was noted in the first chapter (pp29-33) this kind of manipulation is unlikely to surface in any final sense that allows observation. For these reasons, the remainder of this section attempts the examination of the operation of power within health districts from the viewpoints provided by Hindess, Edelman, and Foucault.

These share a common concern with both language and other symbolic orders extended to the influence over what people thought. The assumption here is that what people think informs them in their own political acts or in their acceptance of others' acts. If so, the importance of these symbolic and language forms of power is twofold. First, they were influential features in the process of changing conceptions of the roles of others and self-conceptions. Second, they influenced the beliefs and misconceptions of power itself which many people in the NHS shared. They reinforced beliefs in the ability to influence organisational decisions affecting their conceived interests, while power in its widest dimensions were ignored.

It is here that the use of language gains importance for more often than through compulsion and manipulation, power operates through the ability to articulate an argument. It follows that the more persuasive the argument is, the more consistent its logic, the more knowledge is accepted by others to be encapsulated in it, then the more power is exercised. This relies on an acceptence by others which may or may not be forthcoming and so adds to making power conditional. It may be the personal experience and knowledge which a person can call upon to give their ideas authority which gains a powerful reputation, rather than any blocking or veto power. It may be this which informs people, and is assumed by others to have informed people, in their ideas about what is "rational" according to medical, managerial, or s me other body of knowledge. Authority is granted to those with acknowledged expertise. Experience, contacts, and involvement in previous decisions, are all ingredients in granting this authority to people and in ensuring they have reputations for being powerful.

There is a lack of certainty in this use of power over whether there was an intention to influence thought or to mislead people. Nonetheless, certain acts are meaningless unless they are understood as mechanisms of power and must be regarded as symbolic. Two examples demonstrate this. First, much of Chapter Four described the recorded presentation of policy documents, policy options, consultation processes, and the debates which ensued in health districts during 1982. Much of this, it has to be admitted, made little difference. The eventual outcomes appear almost random. Where change occurred or where influence was

visible (such as the promotion of client-care based units of management by DHA members, p236) it was in areas which meant very little apart from those directly concerned. While the influence of DHAs was admitted in the establishment of client-care based units, this influence was largely restricted to services for the mentally ill and the mentally handicapped (p232). The second example is in the ready acceptence of individual leadership: people to whom the power to get things done could be attributed. Consensus teams worked after a fashion (pp285-95), they allowed compromise and delay in instances which many felt were justified. Nonetheless, strong personalities emerged and the principle of general management found favour. Where it did not, then the individual in the post was faulted (as in Dunhurst pp343-47).

Edelman suggests why and how this remarkable absence of conflict in most situations occurs in two chapters entitled "The administrative system as symbol" and "Political leadership" (1964, pp44-94). If Edelman's position is, as he said in a more recent book, "fairly accurate" then it follows that political manouvre is;

> "itself the end-point of the game; for in the process (rather than in the content of statutes, court decisions, and administrative rules) leaders gain or lose followings, followers achieve a role and a political identity, and money and status are reallocated ..." (1971, p4).

The evidence here is analogous but took place in an organisational setting. The government initiated the 1982 reorganisations and argued for the devolution of authority to more local levels saying that authorities would be more responsive in future to local needs. However, their responsiveness in any real sense remains questionable. Their structure and activity resemble those of a democratic organ similar to those found in local government but their members are selected, not elected, and approved by the organs of central government. Added to which, so much of what they discuss and implement has its origins at central government level or else concerns the minutia of organisational decisions as prepared for them by their officers. (See Charnley, 1983, Klein, 1982 and Haywood, 1983, all mentioned on p123 and see also pp167-68 and pp176-86 for evidence from this investigation.) Generally, this investigation confirmed the limited involvement and influence of most DHAs. Furthermore, people outside the DMT and the DHA, notably the medical and nursing professionals, had only a limited ability to influence decisions further. The limits on time imposed by central government through the RHAs ensured only a limited scope for consultation. And then, such interests as were voiced could be overruled even when the particular argument was accepted as being valid. Sometimes the originally stated priorities and justifications were merely reiterated. Sometimes the justification for overruling an argument was an appeal to the needs of the service or patients as a whole (pp211-223). In many cases the debates were constrained by the fact that most proposals were adopted by the DHA before consultation took place. The DMT gained a vicarious authority by

incorporating DHA approval into the consultation process and the effect of the consultation process was to validate the DMT's power and the policy adopted. Local populations are not effective in voicing their opinions and the means of representation are poorly institutionalised. The consultation required during the 1982 restructuring was limited and access to the process was graded (pp211-23).

These observations can be developed alongside Edelman's ideas. Consultation served only to legitimate power and decisions. The newly created DHAs resemble representative bodies but clearly are not representative. The creation of DHAs by central government would suggest that government intended to give people something in which people would feel more able to participate effectively and so obtain their quiescence. The government may have been preparing for big changes or financial cuts, but nobody can tell, even with hindsight, whether this was on the mind of the government at any time. Central government might been under pressure from medical or other groups, or it might have had its own purposes. It is possible that both of these coincided. As yet, nobody can tell. Openness is a much vaunted characteristic of western democracies and, despite the coming of "glasnost" in the contrasted societies, people here have much higher expectations that they will be consulted which must be fulfilled to some extent if the appearance of democratic politics is to be maintained. "Consultation" and "participation" are terms which underpin democratic politics because reliance is placed on citizen participation and the expectation among populations that the validity of participation and consultation is accepted (Almond and

Verba, 1963). The use of these terms during restructuring in 1982 conferred legitimacy on managerial power and decisions but the sham democracy established with the DHAs has consequences for their meaning. It may also have had consequences for DHAs for, if no-one believes that they are representative, then no-one on the officer team need take seriously the members *attempts to influence* decisions (pp365-67). Despite the view expressed by *some* respondents that DHAs were unnecessary, it could also be argued that there might be value in bringing other forms of expertise to the NHS. At present, however, the low value accorded to DHAs by officers undermines any role that DHAs might have.

Foucault's conception of power as knowledge may be complementary although it is different because it is impersonal and interest-free. The symbolic devolution of authority (pp311-15) may be understood as the act of a government pursuing objectives which they genuinely believed would help them run the NHS. Or perhaps would help government because the NHS would run itself. In which case, the only malevolence would be in any deception used in *pursuit of an objective, not* in the objective itself. With Foucault's conception of power as knowledge, the ideas people have and their acts may be informed by a body of ideas which they had previously adopted and decided to adhere to. As much as helping people think about or know about a topic in a certain way, acquired knowledge can restrict subsequent thought. As much as in the setting of national politics, the language used in an organisational setting may be the necessary and intuitive act of experienced political actors. (It is also possible that when people frame their thoughts they do not always have the language

and terms readily available to them.) So here, while particular terms and language in general are understood as mechanisms of power (rather than as something neutral through which thoughts were conveyed), this is not intended to convey malevolent manipulation in every case. In this investigation, particular attention was directed towards the prevalence and meaning of terms used in the service and it is for this reason that evidence was obtained which related to the language and terms in everyday use as well as the changing formal structural arrangements.

Sometimes this use of language may be attributable to people wishing to exert a deliberate influence, selecting their language and terms very carefully. For instance, the DMT paper in HD 25 described their old structure as "centralist" and so implied that the proposed structure was not (p190). Or, as another example, Heathdown's chairperson who described during interview his Region's action as "blackmail" and so implied that their own reasons were more valid (p264). Other instances may have arisen where the terms used, and therefore the power being used, was not that of a person or group but that of an area of knowledge which was recognised as being of legitimate concern to areas of the health service. Government and others' thoughts were mediated through language and other symbolic forms during the period. It was through language that they conceived of themselves and others. And so, the study showed, people were negotiating the meaning of words and concepts like "participation", "consultation", "client-care based units of management", "Authority", and the "(government's) objectives". There was a clear Regional difference (which cannot be explained here) between the meaning

given to the government's requirement that plans be subject to "consultation" (HC(80)8). Districts in the South West Thames Region were much less willing to allow adequate time than districts in the South East Thames Region. (Of the four districts picked out on p175 where the document had been sent to the RHA before consultation had begun, three were in the South West Thames Region. Of the five districts picked out on p169 as most open to participation, three were in the South East Thames Region.) Another example concerns "authority". The expectation was that authority was being devolved and that local health authorities would be free to make their own structural arrangements in 1982. The events in Heathdown (pp262-265) show the meaning of this term being re-defined - largely by the Region and its officers.

The processes of concept formulation were seen to go on alongside and in parallel with role changes. Indeed, the formulation of concepts, the use of terminology in an agreed and accepted way, was seen as a necessary condition of organisational change. The strength of the medical metaphor may have reinforced the traditional dominance of the profession of medicine in the NHS: the vocabulary of medicine spread outside its original sphere. Terms, such as "crisis" and "breakdown" were common in the language used to explain and understand the organisation. People spoke of government cutting the NHS "to its bare bones".

The next section examines the extent of change and claims that government has made transformation of the NHS because the changes have legitimised another form of knowledge. At this point, it is appropriate to note that with this transformation, other

vocabularies and other metaphores have gained currency and their use may have persuaded people to act in new ways. The changes initiated in 1982, created the need for new concepts to be expressed in new terms. Examples from the 1982 period are "span of control", "delegation", and "client-care based units". These terms acquired a particular meaning and currency within the NHS. More recently, other terms were adopted from management science and organisation theory: other forms of knowledge which were gaining legitimacy within the organisation. "Administration" has given way to "management" and general management may have given the NHS a management with visions of a service planned and funded according to a model based upon commercial practice. They have begun to adopt criteria such as "performance" and management tools with new names such as "clinical budgeting".

In looking at the operation of power through the conceptual frameworks offered by Lukes, Edelman, and Foucault, it is necessary to point out that no-one made reference during interview to recently conceived interests or symbolic politics. Foucault's conception of power is not one that people in the organisation appear to have recognised. The power they recognised was that of the medical professionals, administrators, government and health authority members. It was not the power of medical science or management science. The nearest they came to this was in expressing the view that experience was a valued asset (pp283-84). Sometimes, however, respondents made reference to a specific body of knowledge, medicine (but not management). Perhaps because people were still learning managerial roles, management value was never offered as an explanation for events or trends. Medicine,

on the other hand, was a body of knowledge which excluded any collective responsibility or accepted interest in administration. So, the empirical observations made during the survey phase do not always allow direct links to be made between the articulation of a discourse and the events which occurred in health districts. It was more apparent in the documentation where, for instance, a policy document made reference to one or other basic tenet of management (pp177-78) or medicine (pp243). Of course, this *lack* of direct evidence does not mean that the operation of *power* as Lukes, Edleman, Hindess, or Foucault would recognise it was absent. This is best considered in the next section where the relationship between the government and the districts is examined.

The transformation of power relations in the NHS

In this concluding chapter the emphasis so far has been on the internal power relations of health districts. The influence of government activity and policy has been noted but only as an influence on the operation of power within health districts. That there has been structural changes and changes in the personnel involved in taking decisions cannot be doubted (pp329-54). That the government initiated these throughout the NHS is also not open to question. So what the government was intending and what kind of power was being used on the NHS more generally (in addition to the health districts observed during this investigation) are relevant questions. This section attempts to place the observed changes within a more general context. It takes a wider look at the influence of government and its policies on health districts

and the NHS over time to make more generalised statements but also to explain the significance of the changes observed during this investigation.

Why were these changes made? Did they fit into an overall strategy, and if so, what was it? Did the observed shift from devolution of authority to centralisation (pp311-15) represent a reversal in strategy? These are questions which cannot be answered directly from the evidence of this investigation which observed how power operated within health districts. But these observed changes can be set in the context of information available from other sources.

If power was to be defined as the ability to take or influence decisions, then the evidence for a transformation in the health districts observed and the NHS more generally would be clear enough. Adminstrators, once described as servicing the needs of others (p85-6) have become managers: the health service administration has become the health service management. People have also changed their conception, organisationally and politically, of the role of doctors. The dominance that had once been assumed of them had been modified at a structural level. (Note, the absence of medical involvement in the later restructuring of districts pp329-54 and the limited success in involving them financially in budgets pp362-64.) When interviewed, the cogwheel system - so important or frustrating before 1982 because it was an unreliable control on medical expenditure and impinged little on clinical practice (McLachlan, 1971) - had been forgotten. Doctors no longer have the power to veto decisions

taken by Unit and District Management Teams. Such teams have been replaced by boards with an advisory function: general managers now have the ultimate responsibility for decision-taking. That is not to deny that medical professions retained considerable powers: the 1982 NHS reorganisation and the principle of general management left the structural advantages enjoyed, for instance, by doctors in private practice and in teaching hospitals untouched. The point is that while there have been some structural changes (the importance of which is questionable), these served a symbolic purpose in allowing the possibility of more fundamental changes being introduced.

The principle of general management was only one of several reforms proposed by the NHS Management Inquiry; one which, as a structural change affecting decision-making, corresponded more to the first dimension of power rather than any other. To ascertain whether these organisational changes amounted to a fundamental transformation, and to be consistent with the argument so far, evidence for a transformation in power relations in the NHS has to be sought which recognises that power is conceivable at several levels (pp24-43). One indication of the direction in which things had been moving can be seen in the fact that by 1987 at least two research teams had embarked on a search for genuine cultural changes. Tentatively, Harrison and others (1987) concluded, on the basis of their early investigation of four health districts and their reading of DHSS circulars (DHSS, 1985 and 1986), that management budgeting (since re-named, significantly they argue, "resource management") has failed and that this was because there was nothing in it for most clinicians, nurses, or NHS managers.

As a counter to their tentative conclusions, research in progress in the North West Region suggests, instead, some success in introducing new modes of thought among clinicians (no publications yet). It also suggests that new approaches are being pursued by health service managers. In the opinion of Harrison's team, the government had reached a position where radical and necessary changes could have been introduced but *had failed* at the implementation stage. This failure was because too much emphasis had been directed at the technical or practical difficulties, and not enough on ensuring the commitment of those who would operate the systems and use them for planning.

To pick out one characteristic as an essential in seeking evidence of transformation is somewhat arbitrary and the adoption or otherwise of the techniques of clinical budgeting/resource management may be an inappropriate indicator, given that NHS officers had been adopting managerial roles and attitudes since at least 1982. Management reluctance to push for medical involvement in management though clinical budgeting/resource management is not, perhaps, a surprising finding.

Harrison and others admitted that there are clinicians who would be prepared to involve themselves in resource management and that, given time, their numbers could reach a "critical mass" and so ensure its eventual success but that this might only happen when clinicians were sure that they were in control of the budgets. This suggests that medical power would not be reduced by such a development but this is not necessarily correct. If, with resource management, the priorities and criteria associated with

managerial values were adopted instead of those presently associated with medical values, it would not matter who was taking the decisions.

It is for this reason that it is more appropriate to seek evidence for a transformation of power relations in the NHS in accord with Foucault's conception of power as outlined in Chapter One (pp41-43). Foucault claimed that power arises from "force relations" in society in every interaction. Summed up by Armstrong (1985, p113) "Power creates, particularly individuals and our knowledge of them." and;

> "[Power] flows as a network through the social body, creating us, maintaining us, and the formal centres of power in the society simply represent the concentrations within this generalised force field."

Power is not something that is "acquired, seized, or shared, something that one holds on to or allows to slip away" (Foucault, 1978, p94). Power is not conceived in terms of a struggle against the power of the state or of a specific class. As Foucault has analysed it, power is more subtle and pervasive than repression. He recognised that one of the most important forms of power is "the authority vested in those who speak in the name of the human and natural sciences." (Bernauer, 1982, p91).

To apply this to the health service, any decline or advance in medical or management power should be conceived as decline or advance of an area of knowledge or science rather than in the type of people who may espouse them. This makes it necessary to

examine some characteristics of these bodies of knowledge.

Before restructuring in 1982, Johnson (1972), Mechanic (1979), and Klein (1980) had each predicted a decline in medical domination and indicated what they thought the consequences might be. They predicted an increased ability for administrators to get involved in those areas previously dominated by medical professions. The ethics of resource allocation decisions was so dominated by the medical professions that it had come to be regarded as a branch of medical ethics (Phillips and Dawson, 1985, pp146-170) and ethics was an area included in Johnson's, Mechanic's, and Klein's predictions. Because resource allocation is also a major concern of managerial knowledge, and in the absence of any possible quantitative means of measuring the advance or retreat of cultural values or forms of knowledge, it forms a suitable focus for this discussion. With moves towards clinical budgeting the government recognise[4] that doctors might play some part in these decisions. The government's intention may have been to ensure that such decisions will at some time in the future be taken by general managers but, so far, it has not given any indication. However, with Foucault's conception of power, it is not only who takes decisions that is significant. Far more important is the knowledge base which is applied, worked within or drawn upon. There is a very clear distinction in the critera to be used for resource allocation decisions offered by medicine and by management. As Phillips and Dawson explained in their book (on pp5-16), medical ethics have been vaguely humanitarian. Humanitarian because doctors regarded each individual patient as their responsibility. Vague because they recognised that

compromises had to be reached between the medical profession's ability to meet demands and the state's ability to provide. This was true even without the cash squeeze which has been applied over the last ten years. Compromise was also necessary between individual departments or specialties because medicine was not (and is not) practised single-handed, but in alliance with other professionals, not always medical. The necessity for compromise meant that the grounds used to make resource allocation decisions were never made explicit. This provides one reason why, in the accounts reviewed in the first two chapters, the decision-making processes of the NHS (pp17, 69-70, 81-87) were criticised as arbitrary: the critics observed that the doctors or specialties with the loudest voices got the most resources.

To recapitulate, the conventional wisdom is that politics is to do with the working out of conflicts of (legitimate) interests and so a conventional interpretation of the politics of the health service would be that previous governments, when attempting to improve efficiency, were prepared to allow decision-making processes to be vetoed by medical professionals. The conventional view of politics ensured that the problems of the NHS were defined in terms of the ability of medical professionals to veto decisions throughout its structure (pp65-72). Of course, not all shared that view. Doctors did not. Their view was that medical representation was essential for medical practice, not least because it allowed doctors to defend the rights of patients which were regarded as potentially and constantly endangered by governments and bureaucracies. The predominant view was that doctors shaped the service and administrators administered it on

their behalf. Observers in the past of the organisational politics that resulted from medical influence, such as Haywood and Alaszewski (reviewed on pp82-3), noted that the role of the administrator was confined to managing the mutual adjustment process between medical demands for resources. It was a situation in which it suited the doctors to have administrators at their disposal (not managers) to make the non-medical decisions because doctors defined what the non-medical decisions should be. Because this did not include decisions such as those controlling resource allocation, this was a situation that governments found intolerable (pp71-77).

Doctors defended the process by making reference to medical knowledge. As Phillips and Dawson show, the process was defended on the grounds that the uncertainties of diagnosis and prognosis meant that only doctors were in a position to allocate resources. Medical professionals claimed that their unique specialist knowledge and professional ethics qualified them to decide the necessary balance between equity of resource allocation and the possible equity of outcomes. The vague humanitarian grounds persisted.

The NHS Management Inquiry (DHSS, 1983) which preceded the transformation, guaranteed medical rights to influence decisions but placed general managers above medical representatives. It is not who makes decisions which is important but the knowledge to which they are committed and which qualifies them for their positions. Generally, unit and district general managers have no commitment to humanitarian grounds - no Hippocratic Oath or Geneva

Declaration - but instead have a commitment to efficiency or value for money. This implies a more utilitarian emphasis to decisions. As reinforcement, the government articulated this emphasis with the same degree of moral conviction displayed by medical professionals and by earlier governments concerned with egalitarian resource allocation. By the time the transformation was completed, general managers stood ready to insist that the allocation of health care resources obtain good value and to assess medical procedures by some scale of benefits derived from economics.

Differences between the medical criteria and the increasingly vocal and, perhaps, influential health economist's criteria were well illustrated in an ITV programme entitled "Who lives - who dies" in which Alan Maynard's government funded work was subjected to medical scrutiny. According to these criteria; "[Replacement] hips ... are a much better buy than heart transplants" (Maynard, 1987).

Considered together the fact that people were embarking on research along these lines can be regarded as an indication of the extent of change: observers of the NHS were recognising that a new situation had been reached with the appointment of general managers and experiments with clinical budgeting and were attempting to assess whether this was a fundamental change or not. Others were suggesting and debating proposals based on the work of health economists such as Alan William's "influential" proposal that resources be allocated according to "Quality Adjusted Life Years (QALYs)" (Harris, 1987).

So, here is the relevance of Foucault's conception of power: political processes are explained by reference to the colonisation of an area of social activity by a form of knowledge rather than the working out of interests. Instead of adopting the conventional wisdom and seeing politics as the working out of interests, the operation of power can be seen in the adoption, experimentation, and possible legitimacy of a managerial knowledge rather than a medical. Nevertheless, to consider whether clinical budgeting/resource management, general management, or utilitarian criteria for resource allocation will have fundamental effects on power relations within the NHS is to speculate about events which have occurred or which may occur after the period covered by this study and how they should be interpreted. This investigation can not shed light on this and cannot examine the government's intentions. However, if the shifts in power relations observed in health districts (outlined on pp367-69) occurred elsewhere, they demonstrate how the government was able to create these new conditions. The investigation showed how the structural changes made to health districts and their decision-making processes during 1982-85 were accompanied by changes in role expectation. That is, (with the exception of the new DGM in Dunhurst, p347) managers in the health districts surveyed were not expecting, or expected, to fulfill the same kind of "enabling" role as was described by NHS observers before 1982. (Compare Heathdown's DGM in 1985, p336, with the way he described his position as DA, p291.) These structural changes cannot be ruled out as insignificant while the outcome of research into possible further, more fundamental, changes are awaited.

If, with Edelman, the possibility is admitted that the significance of changes to structures and to the positions of influence went over and above the reasons used to justify them at the time, then their importance (when all the evidence suggests that they were marginal) can be appreciated. The changes enabled a new situation to be reached and this was achieved in two ways. First, they appealed to people's rationality in promoting a decision-making structure which would overrule medical influence in the structure - the cause attributed to the system's previous irrationality. Second, the changes allowed any opponents to think that the changes would not matter because there would be local control and structural representation. The organisation initially appeared - even to those working within the NHS - to be one which was under local control and would be more responsive to local needs than previously. Yet the newly installed devolved authorities were able to offer no real resistence to central government direction and control acting through discourse and through specific policy measures (pp312-16). In this respect, the restructuring of the NHS offers a good illustration of a symbolic political action and the re-creation of the democratic myth so necessary for the operation of power in this country.

Furthermore, and again this is evidence of symbolic political action, the language of management replaced the language of administration. Administration - condemned as bureaucratic, inefficient and unresponsive (pp89-95) - gave way to management which entails the allocation and individualisation of responsibility - and, therefore, takes responsibility for individual and particular decisions away from government.

Furthermore, the government set out, with the implementation of fixed-term contracts for general managers, to make it look as if NHS managers would be accountable in ways similar to that found in commercial practice. What cannot be denied is that a considerable body of people had emerged in the NHS after 1982 who were prepared to accept a responsibility to manage resources when, by all previous accounts, few people had been willing to accept that role before. This is a "significant" change. And it is its significance, its meaning to people within the NHS, which makes it important.

Despite surface appearances, these expectations were quite definite and corresponded to the privileging of individual action or responsibility and private/commercial forms of organisation over public/non-commerical forms which had been adopted from the thinkers of the "new right" (ppl2-14 and pp87-92). It may be that it was the inconsistencies of this body of thought, or the government's interpretation of it, that led to changes in direction at the surface. The government's desire to appoint accountable managers was contrary to its criticisms of centralised state socialism and its stated desire to decentralise. Having just devolved authority in 1982, the solution was to establish the NHS Management Inquiry. While the Inquiry Team claimed that the things which the public and private sectors had in common were just as important as their differences, it then went on to make recommendations for change which were highly prescriptive about the way that DHAs should organise its management. After the government had accepted the Inquiry Team's recommendations, a period followed in which the government ensured that it became

heavily involved in health district management and the appointments that DHAs wanted to make. It is arguable that Griffiths and his team had little influence on the implementation of their findings. Once they had reported, the task of implementation was handed over or taken over by the civil service. The team may well have recognised the need for variety in the implementation of general management but the arm of central government, it now appears, did not.

So, to summarise, there is more to the 1982-1985 period than the mere reorganisation of decision-making and re-naming of decision-takers. There was more to it than the implementation of general management: the officers who once worked in the administration of health districts - including some DAs who had not been made DGMs - were supporting people who regarded themselves as NHS managers and acknowledged that certain qualities are implied by the term "manager". More important than the individualisation of the role was the possibility that the individuals were informed by a body of knowledge which, to give it a label, can be called "management science". While essential myths about legitimate political action were retained, the government continually influenced the roles which (administrative/managerial) people were expected to take in the organisation. If so, the structural changes and changes in personnel taking decisions observed in the health districts used in this investigation (as seen in the previous section) were important in increasing the legitimacy of this area of knowledge in the likelihood of medical opposition. The process of helping this body of knowledge gain ascendency could be enforced with

structural changes and the promotion of people who could demonstrate "relevant" experience when, say, competing to be appointed as general managers.

The crucial difference or distinguishing characteristic between the NHS of before 1982 and that of the NHS at the end of the period of this study is that these managers could be expected (by the government at least) to affect the criteria to be used in future for resource allocation decisions: when previously the service (under licence from government or society) had allowed doctors and administrators to be extremely imprecise about the criteria used. Being in a position to affect the criteria used for resource allocation is one thing, of course, behaving differently or, indeed, being in a frame of mind to do so, is another. And perhaps the government's expectations were ill-founded. While some general managers may appear now to be not so willing to fulfill the role initially expected of them (Harrison, 1987), their initial appointment may have hinged on their ability to demonstrate their "management skills". There is considerable evidence (from this investigation, for instance, in Dunhurst's inability to appoint its new District Administrator as DGM, p342) of government interest and involvement in these appointments.

This speculation implies that the government had deliberate intentions. But does not imply that these should be interpreted as the existence of long-term objectives and a strategy to ensure that these were achieved. This would be to misinterpret power which, as Hindess made clear (pp31-32), should be regarded as

conditional. In discussing the government's intentions it is important to be quite clear what is meant here.

The government's influence during the period was enormous but, as some observers have noted, there does not appear to have been much consistency in its specific actions. This raises the question of whether the outcome of restructuring the NHS was the government's intended outcome because if it was not then a different sort of power was involved: unintended influence. Unfortunately, no direct knowledge of the government's intentions can be claimed at this time. However, consistency need not be associated with the existence of intentions. The point to make here is that power is conditional and so it may be misleading to seek evidence of long-term political strategies. Political strategies must also be conditional. It may be more realistic to say that government had no grand strategy and no ultimate objective and instead acted rather more as someone unexpectedly arriving in a strange city and walking the streets: changing direction and encountering dead-ends and obstruction before deciding that somewhere was more or less suitable as a place to stay the night. Or perhaps the conditional nature of politics can best be seen in what Mrs Thatcher once said;

> "You mustn't win on everything the whole time. So you fight on the thing that really matters and you let the others go. I've got to get this you think. But the other doesn't matter so much, there is another view and you accept it. You just know these things, it's a combination of intuition and experience."

(Interviewed in the Daily Mail, 3rd March 1980, see Daly and George, 1987, p182.)

This gives an insight into the mind of one experienced politician who was probably influential at the time. She was not saying that politicians cannot win every time but that they must not. Only then did she talk about how a choice is made.

Whether the government was initially intent upon a long-term fundamental change in the NHS before 1982 or whether they merely seized an opportunity when they realised they had created it, as far as the health districts studied are concerned, government activity was very influential. This cannot be denied. Government was most visibly influential at a structural or decision-making level but the government's actions in articulating the arguments for efficient management and value for money considerations may also have been persuasive.

General management opened up the possibility that medical knowledge, including medically-defined ethics, would no longer take precedence. It is this which suggests the emergence of a possible transformation of power relations in the NHS. The extent to which new forms of knowledge have been recognised as legitimate by all concerned is something which lies outside this investigation's scope and it may be that the whole edifice of organisational and managerial reforms erected by the government will have little real effect. Of course, if politics has to be described in terms of warring factions, then it never becomes clear who has won the last battle - old patterns may reassert themselves. Here, though, there is no suggestion that

transformation is irreversible. Any associated long-term changes in the fundamental criteria by which resource allocation decisions are assessed and any changes in the legitimacy of organisational roles and action occurred after the period covered by this study. Instead, the period covered was one in which the stage was set for fundamental changes to be introduced. Their adoption and acceptence can only be observed after a time. This study demonstrates the conditions which existed in the health districts selected and how these conditions altered. The point is that during the period covered by this study, medical power was unable to prevent scientific management, economics and business knowledge gaining ascendence. The objections of the medical and nursing professions were not sufficient to prevent general managers being appointed - or to influence the actual appointments - whereas in the recent past the government had shelved the idea in anticipation of resistence ("Patients first", DHSS, 1979).

In making the case that the government was attempting fundamental change and, during the period observed, appeared to be successful, Lukes's "radical" power has been of little use. Apart from the impossibility of knowing the interests of people involved and observing them, the concept of interests has itself proved of little value. People conceive of politics in terms of interests but systematic beliefs and knowledge appear to be more important.

The exercise of power, as has been seen in the NHS, cannot always be assumed to coincide with interests because, for one reason, power can be exercised on behalf of another party. It could be argued, for instance, that the administration acts on behalf of

central government. The 1982 reorganisation of the NHS was ostensibly about delegation, but the limits of this delegation were re-defined by the government from the time officers were appointed (pp313-16).

The same problems associated with the delegation of power and the representation of interests also apply to the medical professions and the government. Doctors, for instance, while claiming to represent their patients were not revealing the extent to which their decision-making and resource allocation activities served the interests of the state and society. It could also be argued that a democratically-elected government acts on behalf of those interests in society and the state it represents, rather than any interests of its own. Yet, as was seen in the first chapter, power has been conceived of in relation to the interests of various parties. Medical dominance did not come about because doctors saw it as in their interests to be powerful, although that was manifest. Instead medical knowledge and medical values colonised areas of social activity.

Interests, then, explain nothing and in fact require explanation. The study has demonstrated that power is not something which can be exchanged or given away: unlike commodities, its use only perpetuates the power of the person(s) using it. It cannot be given away in ways which make it possible for the person(s) receiving it to hold on to it. The exercise of another's power must ultimately be in the interests of those from whom it was delegated. The delegation of power by central government illustrates this and, in the 1982 restructuring, it became obvious

to everyone involved (pp313-16).

This confirms that Foucault's conception of power (1978, pp85-97) - while admittedly difficult to tie down - has more to offer than those liberal or marxist conceptions (pp17-26, notably, Lukes, 1974) which rely on interests to explain behaviour and only differ in how these interests are to be defined (ie; whether by status or by economic position). They make a key assumption that actors' forms of thought are determined by their social location and that interests (based on the calculation of benefits) provide people with ends, as reasons for action. While this latter assumption is not necessarily wrong, it is incomplete because other reasons for action exist, ie; values, fears, and impulses (Hindess, 1986).

Edelman's description of the symbolic effects (purposes) of much political activity has also proved valuable in providing meaning for much that was observed during this investigation. However, no direct causal link between intentions and observed activity can be identified. Foucault's suggestion was that without attempting to mislead people, systematic knowledge (science) is presented and accepted as rational. Why intelligent and reasonable people should allow this to happen appears mysterious. Edelman suggested that politicians and public collude in the perpetuation of democratic political myths, ignoring all inconvenient evidence experienced because of their psychological or perceptual make-up. While this investigation has failed to offer or confirm explanations for why people misconceive their politics, it has demonstrated how, given that people do misconceive events, conditions can be altered so that they may continue to be misled.

The limitations of this research

Finally, the previous section attempted to extend beyond the specific observations made as part of this investigation but important qualifications to its claims need to be noted. There are other problems connected with the gathering of information and their interpretation and these follow.

People interpret the operation of power differently. Researchers and commentators, as well as people affected by or affecting others, have a variety of means available to them on how the operation of power is to be interpreted. Indeed, these conclusions have suggested that the fact that people are likely to interpret events within their organisation in relation to interests may itself have proved conducive to the operation of power. This variety of possible interpretations has been a constant theme running through this investigation and great care was taken in the earlier chapters to make the point that power has often been misconceived in the attempt to make it subject to empirical investigation (a point examined on p26). Nonetheless, empirical work has been conducted and so some assessment of the techniques and conceptual problems encountered in reaching the above conclusions is needed.

While it might be convenient for the sake of clarity to assess the technical and conceptual difficulties separately, they are strongly related. This was seen in the commentaries published earlier and reviewed in Chapters One and Two which tended to conceive of power in a limited fashion, or to ignore it altogether. They incorporated several assumptions about power

without regarding power itself as problematic. Consequently they were able to present findings and conclusions which fitted neatly with their original premisses. There is no doubting the appeal of such tactics but, unfortunately, many of their conclusions now appear illusory. A collective history of the NHS between its formation and 1979 had emerged which portrayed administrators balancing resources in response to medical demands under conditions of local autonomy (pp85-86). Now so much is different. Despite the general conclusion of observers of the NHS that long-term change was unlikely, the previous section illustrates that there has been significant change during the period covered by this study. It is true that these observations have to be treated with caution but - however transient it may turn out to be - change has occurred when all the evidence presented by the writers and social analysts reviewed in Chapters One and Two indicated its impossibility or improbability.

The claims made here might need to be qualified because the observations made during this investigation were confined to two NHS Regions, both of which were resource-losing according to the RAWP formula, and may not have been representative of all that was going on during the period. However, the selection of districts for the survey was made wide and, if not all-embracing, did include two districts that were resource-gaining within their region. There are no grounds for stating that the districts selected were particularly representative of health districts in general. Although they were staffed by people who had often come from other districts, it may be that their DHA members were only typical of people from the South East of England. On the other

hand, there are no grounds for arguing that such people, or such districts, would not be found and would not behave the same elsewhere in the country. It is quite probable that there are districts where clinicians, officer, or DHA members continue to enjoy considerable influence and where the DGM is not effectively a manager. Indeed, such a district was one of those surveyed. So, on this evidence, it can be argued that change occurred because power within all districts was transformed by restructuring, the government's discourse, and the readiness of people to believe in leadership and structural representation described in the earlier sections of this chapter.

As was pointed out at the beginning of Chapter One, the error in so much social policy analysis was its functionalism: parts of a system were investigated in relative isolation from other parts. Another important reason why many accounts have not stood the test of time is their assumption that power is a possession of one group or another. This assumption was linked to another: that political actors or groups (professionals or bureaucrats or governments) possess power and use it in the pursuit of their conceived interests. These assumptions governed the selection of evidence and its subsequent analysis (pp68-73, for instance). The result was that power and political processes in the NHS were modelled as dominated by medical bargaining (pp65-72) and that some doctors bargained from an unassailable position. From here they argued that the NHS was shaped in ways which were directly influenced by the more powerful doctors and specialties and that this was most apparent in resource allocation. Hunter's case study of health service management in Scotland (pp83-4), modified

this argument with the recognition that the respective powers of the groups involved (Hunter's "policy triad") were conditional. Despite this recognition, NHS observers have generally believed that there was something inherent and constant in the power of doctors (hence the term "medical dominance") which was resistant to the demands of patients and governments. Hence, it appeared that health authorities and administrators would never be allowed to make decisions independently of medical demands. Medical power, therefore, was something which doctors wished to continue and which others wished to curtail. Unfortunately, in explaining medical power, they concluded that because medical power was guaranteed by the state in recognition of the nature of medical work, no long-term change in the medical profession's relations with the state was possible.

In this investigation, power has been regarded as an essential but conceptually difficult ingredient in understanding the NHS as an organisation. It has proved impossible to describe the operation of power within the health districts without also considering its operation within the NHS and with government policies as a whole. (For example, in this chapter's earlier discussion of the limited openness of the consultation process which health districts went through as a government requirement.) There are important theoretical differences which need to be re-stated: power is not to be conceived as being solely related to individual or group interests. Hence the relevance and attraction of Foucault's conception of power (1978, pp85-97), reviewed on pp41-3, which explains medical dominance by the colonisation of medical knowledge and medical values into the organisation of health care

and other areas of social activity. Nor does the evidence of this investigation support the notion that power is an attribute possessed by some group or person. If it is possessed at all it is by virtue of their position in relation to some other group or person. These theoretical distinctions should be born in mind when assessing these conclusions.

The consequence of recognising power as an essential but conceptually difficult ingredient is that in drawing conclusions from the observations made during this study, words like "perhaps", "suggest", and "possibly" have had to be used frequently. Empiricists would regard this as unfortunate but, for reasons outlined on pp51-60, the ability to speculate should not be regarded as such a bad thing in science. Indeed, this was the justification for the approach taken in this investigation.

This consequence was particularly evident in the previous section where the attempt was made to assess whether the government was intent upon a fundamental transformation of power relations within the NHS when the evidence for a transformation was itself incomplete. Such a task involves making a judgement over the future and over the unspoken intentions of both government and the people affected. Such judgements are not based on any firm evidence. In any case, the reliability of the available evidence cannot be taken for granted. For instance, the documentary evidence examined in Chapter Four demonstrated the capacity for influence of DHAs. However, at the interview stage, the record proved misleading in two of the four health districts. The DHA in Dunhurst, for instance, appeared to have been influential in its

documentation (p173). Interviews (reported on pp274-5) denied that this was true.

One of the limits of the research methods used was that whole areas of such working practices could not be studied. The re-interpretation and possible alterations of the government's value for money discourse by people within the health districts could not be studied as it happened. The study was limited to the recorded evidence of the decision-making at health authority level and the remembered evidence of those interviewed. The interviews were conducted in a manner intended to allow the respondents to speak in their own terms and their confidentiality ensured that many respondents were able to speak openly. Nevertheless, the agendas were set by the interviewer who had to begin somewhere and so asked questions like "who was influential..." which to some extent determined the kind of answers likely to be given. There is scope here for further research because, if the everyday working practices had been directly observed (arguments and debates over forthcoming decisions, memoranda, and symbols like the size of the office carpet, etc.), the evidence gathered might have been more reliable. Even so, power has been defined here in relation to the ability to influence what people were thinking and, ultimately, what people think is a difficult area to measure with any degreee of certainty. Nonetheless, if there is merit in seeking relative truths (as was argued on p53), then this would be a worthwhile future research task (not in relation to past events, however). Such work would have no guarantees except for the scepticism of others and its internal logical consistency but would allow the possibility of making statements about power.

Chapter Seven
Power in the NHS: 1982 - 1985

As has been argued throughout, a total reliance on empirical observation as a guarantee of truth leads to gross distortion. In this investigation, power was acknowledged as something which could not be adequately conceived or defined by reference to its visible manifestations, and yet empirical work was carried out. This was because there was a concern to observe power's manifestations as a means of understanding the NHS as an organisation rather than for a purely theoretical understanding of power. The intention of the study was investigate the operation of power within the NHS because it was acknowledged that the NHS could not be understood without recognising that much of what (empirically) happens there (or does not happen there) is a consequence of power relations. The task was to attempt an understanding of what was going on while recognising that unknown power relations might remain invisible. Such a task was inevitably frustrating because the means of reaching understanding were inadequate. The concept of power was recognised as one in which empirical evidence may remain concealed. Power as it was conceived and as it could be observed were clearly different. And yet, power as it was conceived would be revealed through empirically observable manifestations, themselves the consequences of the operation of power. It was acknowledged that what could be observed would not be power itself, only the terminal effects of power. It follows that any generalisations about power in the NHS made from these manifestations must be regarded as speculative rather than as known.

A point worth repeating here is that to suppose power operates at one or another dimension is probably faulty; fundamental alterations in power relations appear to occur because power operates across all the dimensions it is possible to identify. And, perhaps, the government's knowledge of this is what gave them advantage over previous governments who have tried to reduce medical power. Too much account can be taken of who makes decisions and who is effective in representing their assumed interests. In this study, the multi-dimensional nature of power was not ignored but, for reasons outlined on pp44-60, this does not allow definitive statements to be made. The problem is that conclusi ns can be drawn at different non-exclusive levels. So, if the same sort of symbolic politics is looked for as was suggested by Edelman (reviewed on pp38), then corresponding evidence can be found and presented from the NHS in the period covered by this study. Again, if there was enough time for objective interests to become apparent, evidence might be found in accord with Lukes's third dimension of power (pp26). At times, it appears, that the most one can say about power is that if a source of power is identified, another source lies further behind. And yet, given that power is a feature of relationships and not a possessed attribute, it can only be discussed with reference to people and groups of people who have relations with others. And, of course, there is no limit to the number of relationships. In this investigation, the focus has been on the relationship between medical and administrative people in the NHS. It has not proved possible to ignore the relationship either of these has had with the government. So, while it is possible to see the government,

say, engaged in all kinds of activity and to associate this with (perhaps party) political intentions, it should not be forgotten that (as with Foucault) it is equally possible to claim that the power of one kind of knowledge was colonising an area of activity (the organisation of health services), and that government, management, and medical professions were merely the conduits for this power and for resistance to it.

Here though, as has already been observed in this chapter, the process occurred over time and so the evidence for this is partly external to the observations made during this investigation and is based on a comparison between the observation of possible acceptence of change in health districts (pp329-67) and the descriptions provided in earlier research. (It was the implications of these descriptions and the predictions which were made that were questioned.)

The perception of change observed during interview brings the discussion back to the question of whether the techniques used were the most appropriate and what were its limitations. As an indication of what model of political process was believed and of the associated political reputations, it was limited to what people said they believed. However, no direct observation of what people thought as such or how it influenced their political behaviour would be possible. While some observation of day-to-day working practices would have been helpful, all empirical observation of power must be treated with caution and scepticism. Even so, there can be no guarantees or statement of absolute truths.

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Appendix
The questionnaires

Questions to ask the District Chairperson

1. When did you take up the chair in this district?

2. Were you a District Health Authority Member previously?

Were you able to pursue any personal interests?

3. Can you recall what were the first tasks you set yourself and what tasks required your immediate attention upon taking up your present position?

4. How do you feel the unit structures have enabled you to carry out the chairman's responsibilities?

5. What would you describe as the intentions of the 1982 reorganisation?

5a What did you hope would be gained by reorganisation?

6. How would you describe the intentions of the consultative document "Patients first"?

7. How far do you think the 1982 reorganisation reflected the intentions behind "Patients first"?

8. Whose formal agreement was necessary for the new managment structure?

9. Were there any people whose informal agreement you considered necessary?

10. How do you feel about the processes by which the reorganisation of 1982 was implemented?

Why do you think that was?

11. What do you think are the reasons for the Griffiths inquiry's changes? ie; what do you think was wrong about the management arrangements that came about after 1982?

12. What influence do you think you had in the development of the new management structures in this district?

13. Which other individuals, or which groups of people, had the most influence in the development of this district's management structures?

Would you be able to list them in order of their influence?

- The District Administrator

- The District Management Team

- Other officers in the district's employ

- The Health authority membership

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- The Medical/Clinical Executive Committee

- No single individual or group

- Other

What role did you think the health authority's members played in the formulation of units of management?

15. Could you describe the influence and individual concerns of these people, or groups of people, in the development of this district's management arrangements?

- The District Administrator

- The District Management Team

- Other officers in the district's employ

- The health authority's membership

- The Medical/ Clinical Executive Committee

- Any others listed at the question above (13)?

17. Do you think the district's new structures took their respective concerns into account satisfactorily?

18. Do you think they still have the same level of concern over these issues?

19. Which issues did you regard as either important or essential as the new management structures were being determined?

- Finance

- Manpower

- Lines of accountability

- A need for strong professional advice

- Any others?

Why do you think that was?

19a. Did you feel that any of these issues and the priorites attached to them conflicted with other priorities or constraints? For example did you feel any conflict between priorities attached to functional and line management considerations?

20. Can you recall any examples that show how these conflicts were resolved?

21. Did you think the choice of basis for the new unit structures was an important issue?

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The questionnaires

Client-care/functional/specialty/clinical/institutional

Why do you think the unit bases were important?

22. Who do you think had the most influence in the choice of basis for the new units?

23. In retrospect, do you now think the management arrangements could have been better?

23a. If so, in what way could they have been better?

23b. If so, when did you become aware of this?

23c. If so, what is presently being done to accomodate this lack? or was anything done?

24. Can you recall if there were any matters concerned you, at the time, that you thought, were not taken fully into account in the new management structures?

25. How far do you think your district's unit structures went towards meeting the objectives of the 1982 reorganisation and "Patients first"?

25a. What reason do you have for thinking that the district was successful?

26. Did the district have additional aims when it embarked upon the reorganisation in 1982?

27. How would you characterise decision-making before the 1982 reorganisation?

Why do you think that was?

28. Can you describe the main effects of the reorganisation upon decision-making in your district?

29. Were these effects immediately apparent, or did they come about much later?

29a. If so, what other things were done by the district's management to encourage these effects?

30. How effective do you think your district has been in encouraging doctors and senior nursing staff to participate in management and policy making?

Why do you think that was?

31. What is it about the structure and management arrangements that have allowed the participation of medical and senior nursing staff?

32. Was the basis of the units of management helpful in allowing this?

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33. How do the processes of changes of 1984 associated with the Griffiths management inquiry differ from those changes made in 1982?

34. Would the same sorts of formal and informal agreements be necessary for the implementation of "Griffiths" in 1984 as were necessary for the reorganisation in 1982?

35. What difference do you think the reorganisation of management that follows the Griffiths inquiry will make to the participation of doctors?

36. What difference do you think the present reorganisation of management will make to the participation of senior nursing staff?

37. Who do you think has had the most influence in the new management arrangements being made in your district?

38. What role do you see for the health authority's members once the general management function has been implemented?

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The questionnaires

Questions to ask the District Administrator

1. When did you take up your post as District Administrator?

1a. Were you District Administrator for the same district before the 1982 reorganisation?

2. What position did you occupy before your appointment as District Administrator?

3. Can you recall what were the first tasks you set yourself and what the tasks were that required your immediate attention upon taking up your present position?

4. Can you briefly outline your responsibilities as District Administrator? Do you feel that the unit structures arrangement enables you to carry out your responsibilities?

5. How would you describe the intentions of the 1982 reorganisation?

6. How far do you think the reorganisation was a reflection of the Governments's plans as outlined in "Patients first"?

7. Whose formal agreement was necessary for the 1982 management structure?

8. Were there any people whose informal agreement you considered necessary?

9. How do you feel about the processes of implementation by which the reorganisation of 1982 was effected?

10. What do you think are the reasons for the Griffiths inquiry's changes? ie; what do you think was wrong about the management arrangements that came about after 1982?

11. What influence do you think you had in the development of the 1982 management structures in this district?

12. Which other individuals, or which groups of people, had the most influence in the development of this district's management structures? Would you be able to list them in an order of influence?

- The Deputy District Administrator
- The District Management Team
- Other officers in the district's employ
- The Health Authority membership
- The Chairperson of the authority
- The Medical/Clinical Executive Committee

- No single individual or group

- Other

What role did you think the health authority's members played in the formulation of units of management?

13. Could you describe the influence and individual concerns of these people or groups of people in the development of this district's management arrangements in 1982?

- The Deputy District Administrator

- The District Management Team

- Other officers in the district's employ

- The Health Authority membership

- The Chairperson of the authority

- The Medical/Clinical Executive

- Any others listed at question 12

14. Do you think the district's new structures took all their respective concerns into account satisfactorily?

15. Do you think they still have the same level of concern over these issues?

16. Which issues did you personally regard as either important or essential as the 1982 management structures were being determined?

- Finance

- Manpower

- Lines of accountability

- A need for strong professional advice

- Any others?

17. Did you feel that any of these issues, and the priorites attached to them, conflicted with other priorities or constraints?

For example, did you feel any conflict between priorities attached to functional or line management considerations?

17b. How were these conflicts resolved?

Can you recall any examples how these conflicts were resolved?

18. In retrospect, do you now think the management arrangements could have been better?

18a. If so, in what way could they have been better?

18b. If so, when did you become aware of this?

18c. If so, what is presently being done to accomodate this? or was anything done?

19. Can you recall which matters concerned you, at the time, that you thought were not taken fully into account in the new management structures?

20. Did you think the choice of basis for the new unit structures was an important issue?

Client-care/functional/specialty/clinical/institutional

Why do you think the unit bases were important?

20a. Why do you think your district chose the types of units that it has?

21. Who do you think had the most influence in the choice of basis for the new units?

22. How far do you think your district's unit structures went towards meeting the objectives of the 1982 reorganisation (and "Patients first") ?

22a. What reasons do you have for reaching that conclusion?

23. Did the District have additional aims when it embarked upon the the reorganisation in 1982?

24. How would you characterise management style (decision making) before the 1982 reorganisation? (prefer respondant's own choice of words [but could be slow/ autocratic/ democratic/ good/ bad, etc]

25. Can you describe the main effects of the reorganisation in 1982 upon decision-making and management style in your district?

25a. Were these effects immediately apparent, or did they come about much later?

26. How effective do you think your district has been in encouraging doctors to participate in management and policy making?

Has the 1982 reorganisation changed the role of medical staff in management?

Were unit structures instrumental in this?

27. How effective do you think your district has been in encouraging the involvement of senior nursing staff in management and policy making?

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Has the 1982 reorganisation changed the role of nursing staff in management?

Were unit structures instrumental in this?

28. How do the processes of implementation of those changes being made now, attributeable to Griffiths, differ from the implementation of those changes made in 1982?

29. Would the same sorts of formal and informal agreements be necessary for the implementation of "Griffiths" in 1984 as were necessary for the reorganisation in 1982?

30. What difference do you think the reorganisation of management that follows the Griffiths inquiry will make to the participation of doctors?

31. What difference do you think the present reorganisation of management will make to the participation of senior nursing staff?

32. Who do you think has had the most influence in the new management arrangements being made in your district?

32a. Who else has been influential ?

33. What role do you see for the health authority's members once the general management function has been implemented?

Appendix
The questionnaires

Questions to ask the Deputy District Administrator

1. When did you take up your post as Deputy District Administrator?

1a. Were you Deputy District Administrator for the same district before the 1982 reorganisation?

2. What position did you occupy before your appointment as Deputy District Administrator?

3. Can you recall what were the first tasks you set yourself and what the tasks were that required your immediate attention upon taking up your present position?

Would you prefer to have time to think about this question, if so, then I could arrange to return in, say, about a weeks time?

4. Apart from deputising for your District Administrator, can you briefly outline your responsibilities. Do you feel that the unit structures arrangement enables you to carry out your responsibilities?

5. Would you be able describe as the intentions of the 1982 reorganisation?

6. What did you think would be gained by the reorganisation?

7. How far do you think the reorganisation was a reflection of the Governments's plans as outlined in "Patients first"?

8. Whose formal agreement was necessary for the new managment structure?

9. Were there any people whose informal agreement you considered necessary?

10. How do you feel about the processes by which the reorganisation of 1982 was implemented?

11. What do you think are the reasons for the Griffiths inquiry's changes? ie; what do you think was wrong about the management arrangements that came about after 1982?

12. What influence do you think you had in the development of the 1982 management structures in this district?

12a. Which individual, or which group of people, in the organisation, do you think, had the most influence in the development of this district's management structures?

- The District Administrator

- The District Management Team

- Other officers in the district's employ

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- The Health Authority membership

- The Chairman of the authority

- The Medical/Clinical Executive Committee

- No single individual or group

- Other

What role did you think the health authority's members played in the formulation of units of management?

13. Who else was influential in the process of implementing the 1982 reorganisation?

13a. Would you be able to list them in any order of their influence?

13b. Could you describe the influence and individual concerns of these people or groups of people in the development of this district's management arrangements in 1982?

- The District Administrator

- The District Management Team

- Other officers in the district's employ

- The Health Authority membership

- The Chairperson

- The Medical/Clinical Executive

- Other

Would you prefer to think some more about this question? If so, then I could return later.

15. Do you think the district's new structures took all their respective concerns into account satisfactorily?

16. Do you think they still have the same level of concern over these issues?

17. Which issues did you personally regard as either important or essential as the 1982 management structures were being determined?

- Finance

- Manpower

- Lines of accountability

- A need for strong professional advice

- Any others?

17a. Did you feel that any of these issues, and the priorites attached to them, conflicted with other priorities or constraints?

For example, did you feel any conflict between priorities attached to functional or line management considerations?

17b. Were these conflicts resolved? Can you recall any examples how these conflicts were resolved?

18. In retrospect, do you now think the management arrangements could have been better?

18a. If so, in what way could they have been better?

18b. If so, when did you become aware of this?

18c. If so, what is presently being done to accomodate this lack? or was anything done?

19. Can you recall which matters concerned you, at the time, that you thought were not taken fully into account in the new management structures?

20. Did you think the choice of basis for the new unit structures was an important issue?

Client-care/functional/specialty/clinical/institutional

Why do you think the unit bases were important?

20a. Who would you say had the most influence in the choice of basis for the new units?

21. How far do you think your district's unit structures went towards meeting the objectives of the 1982 reorganisation (and "Patients first") ?

21a. What reasons do you have for reaching that conclusion?

22. Did the district have additional aims when it embarked upon the reorganisation in 1982?

23. How would you characterise management style (decision making) before the 1982 reorganisation? (prefer respondant's own choice of words [but could be slow/ autocratic/ democratic/ good/ bad, etc]

24. Can you describe the main effects of the reorganisation upon decision-making in your district?

25. Were these effects immediately apparent, or did they come about much later?

25a. Were there any other factors which might have caused these changes?

26. How effective do you think your district has been in encouraging doctors to participate in management and policy making?

Has the 1982 reorganisation changed the role of medical staff in management?

Were unit structures instrumental in this?

27. How effective do you think your district has been in encouraging the involvement of senior nursing staff in management and policy making?

Has the 1982 reorganisation changed the role of nursing staff in management?

Were unit structures instrumental in this?

30. How do the processes of implementation of those changes being made now, attributeable to Griffiths, differ from those the implementation of the changes made in 1982?

31. Would the same sorts of formal and informal agreements be necessary for the implementation of "Griffiths" in 1984 as were necessary for the reorganisation in 1982?

32. What difference do you think the reorganisation of management that follows the Griffiths inquiry will make to the participation of doctors?

33. What difference do you think the present reorganisation of management will make to the participation of senior nursing staff?

34. Who do you think has had the most influence in the management arrangements being made now in your district?

35. What role do you see for the health authority's members once the general management function has been implemented?

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The questionnaires

Questions to ask the Chairperson of District Medical Executive Committee

1. When did you become Chairman of the District Medical Executive Committee?

2. Were you Chairman of the District Medical Executive before the 1982 reorganisation?

Were you able to pursue any personal interests?

3. Can you briefly outline the role of the DMEC, and describe why you wanted to become involved with it as chairman.

4. Do you feel the district's unit structures and its management arrangements are compatible with your responsibilities as chairman and with the role of the DMEC?

(probe) Do they enable you to influence decisions in the way you would wish?

5. Would you be able to describe the purpose of the 1982 reorganisation of the NHS?

6. Would you be able to describe the processes by which the 1982 reorganisation was implemented?

6a. Whose formal agreement was necessary for the new managment structure?

6b. Were there any people whose informal agreement was also considered necessary?

8. What influence do you think your committee had in the development of the new management structures in this district?

8a. Which individual, or which group of people, in the organisation, do you think, had the most influence in the development of the management structures?

What role did you think the health authority's members played in the formulation of units of management?

9. Who else was influential in the process of implementing the 1982 reorganisation in this District?

9a. Would you be able to describe, individually, their role in influencing the management structures determined in this district?

10. Would you be able to describe their, individual, concerns at the time of the implementation of the 1982 reorganisation?

11. Do you think that the district's new structures took into account these people's respective concerns satisfactorily?

(probe) Do you know of any expressions of disatisfaction with the new structures?

12. Which issues did you personally regard as either important or essential as the new management structures were being determined?

12a. Did you feel that any of these issues and the priorites attached to them conflicted with other priorities or constraints? (perhaps expressed by management or other professionals)

12b. Can you recall any examples that show how these conflicts were resolved?

13. Did you think the choice of basis for the new unit structures was an important issue?

Client-care/functional/specialty/clinical/institutional

Why do you think the unit bases were important?

13a. Who do you think had the most influence in the choice of basis for the new units?

14. In retrospect, do you now think the management arrangements could have been better?

14a. If so, in what way could they have been better?

14b. If so, when did you become aware of this?

14c. If so, what is presently being done to accomodate this lack? or was anything done?

15. How far do you think your district's unit structures and management arrangements went towards meeting the government's stated objectives when reorganising the NHS in 1982?

15a. What reason do you have for thinking that the district was successful?

16. Do you think that people in the district had aims when it reorganised in 1982 that were additional to those being pushed by Central Government and the RHA?

17. Can you describe the main effects of the reorganisation upon decision-making in your district?

(probe) What was decision-making like before and after 1982?

(probe) How able was your committee to influence decisions before and after?

18. Were these effects immediately apparent, or did they come about much later?

19. If so, what other things were done by the district's management to encourage these effects?

20. How effective do you think your district has been in encouraging doctors to participate in management and policy making?

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20a. How effective do you think your district has been in encouraging the involvement of senior nursing staff in management and policy making?

21. Was the units of management structure that the district has adopted helpful in this?

22. What is it about the structure, and management arrangements that allow the participation of medical, nursing, and other staff in the processes of policy making.

23. What do you think are the reasons for the Griffiths inquiry's changes? ie; what do you think was wrong about the management arrangements that came about after 1982?

24. How do the processes of change in 1984 associated with the Griffiths management inquiry differ from those changes made in 1982?

25. Would the same sorts of formal and informal agreement be necessary for the implementation of "Griffiths" in 1984 as were necessary f r the reorganisation in 1982?

26. What difference do you think the reorganisation of management that follows the Griffiths inquiry will make to the participation of doctors?

27. What difference do you think the present reorganisation of management will make to the participation of senior nursing staff?

28. Who do you think has had the most influence in the new management arrangements being made in your district?

29. What role do you see for the health authority's members once the general management function has been implemented?

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Questions to ask the District Medical Officer

1. When did you take up your post as District Medical Officer?

1a. Were you District Medical Officer *for the same district* before the 1982 reorganisation?

2. What position did you occupy before your appointment as District Medical Officer?

Were you able to pursue any personal interests?

3. Can you recall what were the first tasks you set yourself and what the tasks were that required your immediate attention upon taking up your present position?

4. How do you feel the unit structures enable you to carry out your own particular responsibilities?

5. What would you describe as the intentions of the circular HC(80)8?

6. How would you describe the intentions of the consultative document "Patients first"?

Would you prefer to have time to think about this question? If so, then I could arrange to return later.

7. How far do you think the circular reflected the intentions of "Patients first"?

8. Whose formal agreement was necessary for the new managment structure?

9. Were there any people whose informal agreement you considered necessary?

10. How do you feel about the processes of implementation by which the reorganisation of 1982 was effected?

11. What do you think are the reasons for the Griffiths inquiry's changes? ie; what do you think was wrong about the management arrangements that came about after 1982?

12. What influence do you think you had in the development of the new management structures in this district?

12a. Which individual, or which group of people, in the organisation, do you think, had the most influence in the development of the management structures?

What role did you think the health authority's members played in the formulation of units of management?

13. Who else was influential in the process of implementing HC(80)8?

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13a. How would you describe, individually, their role in influencing the management structures determined in this district?

14. How would you describe their, individual, concerns at the time of implementation of HC(80)8?

Would you prefer to think some more about this question? If so, then I could return later.

15. If justified, do you think the district's new structures took these their respective concerns into account satisfactorily?

16. Do you think they are also satisfied that the unit structures take these concerns of theirs into account?

16a. Do you think they still have the same level of concern over these issues?

17. Which issues did you regard as either important or essential as the new management structures were being determined?

17a. Did you feel that any of these issues and the priorites attached to them conflicted with other priorities or constraints?

17b. Can you recall any examples that show how these conflicts were resolved?

18. Did you think the choice of basis for the new unit structures was an important issue?

Client-care/functional/specialty/clinical/institutional

Why do you think the unit bases were important?

19. Who do you think had the most influence in the choice of basis for the new units?

20. In retrospect, do you now think the management arrangements could have been better?

20a. If so, in what way could they have been better?

20b. If so, when did you become aware of this?

20c. If so, what is presently being done to accomodate this lack? or was anything done?

21. Can you recall which matters concerned you, at the time, that you thought were not taken fully into account in the new management structures?

22. How far do you think your district's unit structures went towards meeting the objectives of "Patients first" and HC(80)8?

23. What reason do you have for thinking that the district was successful?

24. Did the district have additional aims when it embarked upon the reorganisation in 1982?

25. How would you characterise decision-making before the 1982 reorganisation?

26. Can you describe the main effects of the reorganisation upon decision-making in your district?

27. Were these effects immediately apparent, or did they come about much later?

28. If so, what other things were done by the district's management to encourage these effects?

29. How effective do you think your district has been in encouraging doctors to participate in management and policy making?

30. How effective do you think your district has been in encouraging the involvement of senior nursing staff in management and policy making?

31. Was the units of management structure that the district has adopted helpful in this?

32. What is it about the structure, and management arrangements that allow the participation of medical, nursing, and other staff in the processes of policy making.

33. How do the processes of changes in 1984 associated with the Griffiths management inquiry differ from those changes made in 1982?

35. What difference do you think the reorganisation of management that follows the Griffiths inquiry will make to the participation of doctors?

36. What difference do you think the present reorganisation of management will make to the participation of senior nursing staff?

37. Who do you think has had the most influence in the new management arrangements being made in your district?

38. What role do you see for the health authority's members once the general management function has been implemented?

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Questions to ask the District Nursing Officer

1. When did you take up your post as District Nursing Officer?

1a. Were you District Nursing Officer for the same district before the 1982 reorganisation?

2. What position did you occupy before your appointment as District Nursing Officer?

3. Can you recall what were the first tasks you set yourself and what the tasks were that required your immediate attention upon taking up your present position?

Would you prefer to have time to think about this question, if so, then I could arrange to return in, say, about a weeks time?

4. How do you feel the unit structures enable you to carry out your own particular responsibilities?

5. What would you describe as the intentions of the circular HC(80)8?

6. How would you describe the intentions of the consultative document "Patients first"?

Would you prefer to have time to think about this question? If so, then I could arrange to return later.

7. How far do you think the circular reflected the intentions of "Patients first"?

8. Whose formal agreement was necessary for the new managment structure?

9. Were there any people whose informal agreement you considered necessary?

10. How do you feel about the processes of implementation by which the reorganisation of 1982 was effected?

11. What do you think are the reasons for the Griffiths inquiry's changes? ie; what do you think was wrong about the management arrangements that came about after 1982?

12. What influence do you think you had in the development of the new management structures in this district?

12a. Which individual, or which group of people, in the organisation, do you think, had the most influence in the development of the management structures?

What role did you think the health authority's members played in the formulation of units of management?

13. Who else was influential in the process of implementing HC(80)8?

13a. How would you describe, individually, their role in influencing the management structures determined in this district?

14. How would you describe their, individual, concerns at the time of implementation of HC(80)8?

15. If justified, do you think the district's new structures took these their respective concerns into account satisfactorily?

16. Do you think they are also satisfied that the unit structures take these concerns of theirs into account?

16a. Do you think they still have the same level of concern over these issues?

17. Which issues did you regard as either important or essential as the new management structures were being determined?

17a. Did you feel that any of these issues and the priorites attached to them conflicted with other priorities or constraints?

17b. Can you recall any examples that show how these conflicts were resolved?

18. Did you think the choice of basis for the new unit structures was an important issue?

Client-care/functional/specialty clinical/institutional

Why do you think the unit bases were important?

18a. Who do you think had the most influence in the choice of basis for the new units?

19. In retrospect, do you now think the management arrangements could have been better?

19a. If so, in what way could they have been better?

19b. If so, when did you become aware of this?

19c. If so, what is presently being done to accomodate this lack? or was anything done?

20. Can you recall which matters concerned you, at the time, that you thought, were not taken fully into account in the new management structures?

21. How far do you think your district's unit structures went towards meeting the objectives of "Patients first" and HC(80)8?

21a. What reason do you have for thinking that the district was successful?

22. Did the district have additional aims when it embarked upon the reorganisation in 1982?

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23. How would you characterise decision-making before the 1982 reorganisation?

24. Can you describe the main effects of the reorganisation upon decision-making in your district?

25. Were these effects immediately apparent, or did they come about much later?

25a. If so, what other things were done by the district's management to encourage these effects?

26. How effective do you think your district has been in encouraging doctors to participate in management and policy making?

26a. How effective do you think your district has been in encouraging the involvement of senior nursing staff in management and policy making?

28. What is it about the structure, and management arrangements that allow the participation of medical, nursing, and other staff in the processes of policy making.

29. How do the processes of change of 1984 associated with the Griffiths management inquiry differ from those changes made in 1982?

30. Would the same sorts of formal and informal agreement be necessary for the implementation of "Griffiths" in 1984 as were necessary for the reorganisation in 1982?

31. What difference do you think the reorganisation of management that follows the Griffiths inquiry will make to the participation of doctors?

32. What difference do you think the present reorganisation of management will make to the participation of senior nursing staff?

33. Who do you think has had the most influence in the new management arrangements being made in your district?

34. What role do you see for the health authority's members once the general management function has been implemented?

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Questions to ask the chairperson of the District Staff Consultative Committee

1. When did you take up the position of chairperson of the District Staff Consultative Committee?

2. Had you been an ordinary member of the committee beforehand?

Were you able to pursue any personal interests?

3. Do you feel the unit structures, established as a result of the 1982 reorganisation, enable you to carry out your own role on the District Staff Consultative Committee?

4. What would you describe as the intentions of the circular HC(80)8?

5. How would you describe the intentions of the consultative document "Patients first"?

Would you prefer to have time to think about this question? If so, then I could arrange to return later.

6. How far do you think the circular itself reflected the intentions of "Patients first"?

7. Can I ask you to think back to the consultation processes? Can I ask you whose formal agreement was necessary locally for the districts new structure?

8. Were there any people whose informal agreement was considered necessary?

9. How do you feel about the processes by which the reorganisation of 1982 was effected?

10. What do you think are the reasons behind the changes being made as a result of the Griffiths management inquiry? ie; what do you think was wrong about the management structures that came about as a result of the 1982 reorganisation?

11. What influence did the Consultative Committee have in the development of the new unit structures in this district?

12. Which individual, or which group of people, in the organisation, do you think, had the most influence in the development of the management structures?

What role did you think the health authority's members played in the formulation of units of management?

13. Who else was influential in the process of implementing HC(80)8?

14. How would you describe, individually, their role in influencing the management structures determined in this district?

15. How would you describe their, individual, concerns at the time of implementation?

Would you prefer to think some more about this question? If so, then I could return later.

16. Which issues did you regard as either important or essential as the new structures were being determined?

16a. Did you feel that any of these issues and the priorites attached to them conflicted with other priorities or constraints?

16b. Can you recall any examples that show how these conflicts were resolved?

16c. Did any of the priorities of management conflict with your own?

17. Did you think the choice of basis for the new unit structures was an important issue?

Client care/functional/specialty/institutional

Why do you think the unit bases were important?

18. Who do you think had the most influence in the choice of basis for the district's new units?

19. In retrospect, do you now think the management structure arrangements could have been better?

19a. If so, in what way could they have been better?

19b. If so, when did you become aware of this?

19c. If so, what is presently being done to accomodate this lack? or was anything done?

20. Can you recall which matters concerned you, at the time, that you thought were not taken fully into account in the unit structures?

21. How far do you think your district's unit structures went towards meeting the objectives of "Patients first" and HC(80)8?

21a. What reason do you have for thinking that the district was successful?

22. Did the district have additional aims when it embarked upon the reorganisation in 1982?

23. How would you characterise decision-making before the 1982 reorganisation?

24. Can you describe the main effects of the reorganisation upon decision-making in your district?

25. Were these effects immediately apparent, or did they come about much later?

25a. If so, what other things were done by the district's management to encourage these effects?

26. How effective do you think your district has been in encouraging doctors to participate in management and policy making?

27. How effective do you think your district has been in encouraging the involvement of senior nursing staff in management and policy making?

28. What is it about the structure, and management arrangements that allow the participation of medical, nursing, and other staff in the processes of policy making.

29. Is the units of management structure that the district has adopted helpful in this?

30. How do the processes of change in 1984 associated with the Griffiths management inquiry differ from those changes made in 1982?

31. Do you have similar hopes for/doubts about/ the changes that will come about as a result of the Griffiths management inquiry?

31b. Do you think that the consultative processes will be altered radically when your district has a general manager?

32. What difference do you think the reorganisation of management that follows the Griffiths inquiry will make to the participation of doctors?

33. What difference do you think the present reorganisation of management will make to the participation of senior nursing staff?

34. Who do you think has had the most influence in the new management arrangements being made in your district?

35. What role do you see for the health authority's members once the general management function has been implemented?

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Questions to ask the District Treasurer

1. When did you take up your post as District Treasurer?

1a. Were you District Treasurer for the same district before the 1982 reorganisation?

2. What position did you occupy before your appointment as District Treasurer?

3. Can you recall what were the first tasks you set yourself and what the tasks were that required your immediate attention upon taking up your present position?

Were you able to pursue any personal interests?

4. How do you feel the unit structures enable you to carry out your own particular responsibilities?

5. What would you describe as the intentions of the circular HC(80)8?

6. How would you describe the intentions of the consultative document "Patients first"?

7. How far do you think the reorganisation was a reflection of the Government's plans as outlined in "Patients first"?

8. Whose formal agreement was necessary for the new managment structure?

9. Were there any people whose informal agreement you considered necessary?

10. How do you feel about the processes of implementation by which the reorganisation of 1982 was effected?

11. What do you think are the reasons for the Griffiths inquiry's changes? ie; what do you think was wrong about the management arrangements that came about after 1982?

12. What influence do you think you had in the development of the new management structures in this district?

12a. Which individual, or which group of people, in the organisation, do you think, had the most influence in the development of the management structures?

What role did you think the health authority's members played in the formulation of units of management?

13. Who else was influential in the process of implementing HC(80)8?

13a. How would you describe, individually, their role in influencing the management structures determined in this district?

14. How would you describe their, individual, concerns at the time of implementation of HC(80)8?

Would you prefer to think some more about this question? If so, then I could return later.

15. If justified, do you think the district's new structures took these their respective concerns into account satisfactorily?

16. Do you think they are also satisfied that the unit structures take these concerns of theirs into account?

16a. Do you think they still have the same level of concern over these issues?

17. Which issues did you regard as either important or essential as the new management structures were being determined?

17a. Did you feel that any of these issues and the priorites attached to them conflicted with other priorities or constraints?

17b. Can you recall any examples that show how these conflicts were resolved?

18. Did you think the choice of basis for the new unit structures was an important issue?

Client-care functional/specialty/clinical/institutional

Why do you think the unit bases were important?

18a. Who do you think had the most influence in the choice of basis for the new units?

19. In retrospect, do you now think the management arrangements could have been better?

19a. If so, in what way could they have been better?

19b. If so, when did you become aware of this?

19c. If so, what is presently being done to accomodate this lack? or was anything done?

20. Can you recall which matters concerned you, at the time, that you thought, were not taken fully into account in the new management structures?

21. How far do you think your district's unit structures went towards meeting the objectives of "Patients first" and HC(80)8?

21a. What reason do you have for thinking that the district was successful?

22. Did the district have additional aims when it embarked upon the reorganisation in 1982?

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23. How would you characterise decision-making before the 1982 reorganisation?

24. Can you describe the main effects of the reorganisation upon decision-making in your district?

25. Were these effects immediately apparent, or did they come about much later?

25a. If so, what other things were done by the district's management to encourage these effects?

26. How effective do you think your district has been in encouraging doctors to participate in management and policy making?

26a. How effective do you think your district has been in encouraging the involvement of senior nursing staff in management and policy making?

27. Was the units of management structure that the district has adopted helpful in this?

28. What is it about the structure, and management arrangements that allow the participation of medical, nursing, and other staff in the processes of policy making.

29. How do the processes of change of 1984 associated with the Griffiths management inquiry differ from those cnanges made in 1982?

30. Would the same sorts of formal and informal agreement be necessary for the implementation of "Griffiths" in 1984 as were necessary for the reorganisation in 1982?

31. What difference do you think the reorganisation of management that follows the Griffiths inquiry will make to the participation of doctors?

32. What difference do you think the present reorganisation of management will make to the participation of senior nursing staff?

33. Who do you think has had the most influence in the new management arrangements being made in your district?

34. What role do you see for the health authority's members once the general management function has been implemented?

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Questions to ask a GP with representative functions at district level

1. Can I begin by asking you to describe the main areas of your work and which unit of *administration* you are most closely connected with?

2. Do you feel the district's unit structures and its management arrangements enable you to influence decisions in the way you would wish?

Were you able to pursue any personal interests?

3. Would you be able to describe the purpose of the 1982 reorganisation of the NHS?

4. Would you be able to describe the processes by which the 1982 reorganisation was implemented?

4a. Whose formal agreement was necessary for the 1982 managment structure?

4b. Were there any people whose informal agreement was also considered necessary?

5. What influence do you think you were able to bring to bear in the development of the 1982 management structures in this district?

5a. Which individual, or which group of people, in the organisation, do you think, had the most influence in the development of this district's management structures?

- The District Administrator

- The District Management Team as a whole

- Other officers in the District's employ

- The Health Authority's membership

- The Chairperson of the authority

- The clinical/medical executive committee

- An other (Finance officer, District Works, District Medical Records Officer, etc -able to make a case for unit/district based control of their activities)

- No single individual or group

What role did you think the health authority's members played in the formulation of units of management?

6. Could you describe the influence and individual concerns of these people or groups of people in the development of this district's management arrangements in 1982?

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- The District Administrator

- The District Management Team as a whole

- Other offiers in the District's emply

- The Health authority's membership

- The Chairperson of the authority

- The clinical/medical executive committee

- An other

- No single individual or group

7. Do you know of any expressions of disatisfaction with the new structures?

8. Which issues did you personally regard as either important or essential as the new management structures were being determined?

- Finance

- Manpower

- Lines of accountability

- a need for strong professional advice

- a need for clinical and administrative staff to relate well

- Any others? please detail

8a. Did you feel that any of these issues and the priorites attached to them, conflicted with other priorities or constraints? perhaps expressed by management or professionals)

9. How were these conflicts resolved?

10. In retrospect, do you now think the management arrangements could have been better?

10a. If so, in what way could they have been better?

10b. If so, when did you become aware of this?

10c. If so, what is presently being done to accomodate this lack? or was anything done?

11. Did you think the choice of basis for the new unit structures was an important issue?

Client-care/functional/specialty/clinical/institutional

Why do you think the unit bases were important?

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11a. Who do you think had the most influence in the choice of basis for the new units?

12. How far do you think your district's unit structures and management arrangements went towards meeting the government's stated objectives when reorganising the NHS in 1982?

12a. What reason do you have for reaching that conclusion?

13. Do you think that people in the district had aims when it reorganised in 1982 that were additional to those being pushed by Central Government and the RHA?

14. Can you describe the main effects of the reorganisation upon decision-making or management style in your district?

(probe) What was decision-making like before and after 1982?

15. Were these effects immediately apparent, or did they come about much later?

16. If so, what other things were done by the district's management to encourage these effects?

17. How effective do you think your district has been in encouraging doctors to participate in management and policy making?

18. How effective do you think your district has been in encouraging the involvement of senior nursing staff in management and policy making?

21. What is it about the structure, and management arrangements that allow the participation of medical, nursing, and other staff in the processes of policy making.

22. What do you think are the reasons for the Griffiths inquiry's changes? ie; what do you think was wrong about the management arrangements that came about after 1982?

23. How do the processes of change in 1984 associated with the Griffiths management inquiry differ from those changes made in 1982?

24. Would the same sorts of formal and informal agreement be necessary for the implementation of "Griffiths" in 1984 as were necessary for the reorganisation in 1982?

25. What difference do you think the reorganisation of management that follows the Griffiths inquiry will make to the participation of doctors?

26. What difference do you think the present reorganisation of management will make to the participation of senior nursing staff?

27. Who do you think has had the most influence in the new management arrangements being made in your district?

28. What role do you see for the health authority's members once the general management function has been implemented?

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Questions to ask an ordinary member of the health authority

1. When did you become a member of this health authority?

2. Were you a member of an Area Health Authority before?

3. What personal reasons did you have for wanting to become a member of the authority in 1982?

3a. What did you hope to achieve?

3b. And what did you think you could bring to the health authority?

3c. Can you recall what were the first tasks you set yourself?

4. Do you think that the District's unit structures have enabled, or do enable, you to act in pursuance of the objectives you have listed?

5. What would you describe as the intentions of the 1982 reorganisation?

6. Could you also describe the intentions of the consultative document "Patients first"?

7. Did you, as a member, feel involved in the processes of implementation by which the reorganisation of 1982 was effected?

8. What do you think are the reasons for the Griffiths inquiry's changes?

8a. What do you think was wrong about the management arrangements that came about after 1982?

9. What influence do you think health authority members had in the development of the new management structures in this district?

10. Could you identify individuals, or groups of people, in the district, who you think had the most influence in the development of the management structures?

11. Whose formal agreement was necessary for the new managment structure?

12. Were there any people whose informal agreement you considered necessary?

13. Who else was influential in the process of implementing the 1982 reorganisation?

14. You have already outlined why you decided to join the health authority, what would you think were the reasons that other people decided to join it? Did any of them have any particular "axes to grind"?

15. How would you describe their, individual, concerns at the time of implementation of 1982 reorganisation?

16. Do you think the district's new structures took their respective concerns into account satisfactorily?

17. Do you think they still have the same level of concern over these issues?

18. Which issues did you personally regard as either important or essential as the new management structures were being determined?

19. Did you feel that (this issue) any of these issues and the priorites attached to them conflicted with other priorities or constraints?

20. Can you recall any examples that show how these conflicts were resolved? What did you think the district had to do in order to take account of these?

21. Did you think the choice of basis for the new unit structures was an important issue?

Client-care/functional/specialty/clinical/institutional

Why do you think the unit bases were important?

22. Who do you think had the most influence in the choice of basis for the new units?

23. In retrospect, do you now think the management arrangements could have been better?

23a. If so, in what way could they have been better?

23b. If so, when did you become aware of this?

23c. If so, what has been done to change the arrangements?

24. Can you recall if there were any matters concerned you, at the time, that you thought were not taken fully into account in the new management structures?

25. How far do you think your district's unit structures went towards meeting the objectives of the 1982 reorganisation or of "Patients first" ?

(probe) what reason do you have for thinking that?

26. Did the district have additional aims when it embarked upon the reorganisation in 1982?

27. Can you describe the main effects of the reorganisation upon decision-making in the NHS?

28. If so, what other things were done by the district's management to encourage these effects?

29. How effective do you think your district has been in encouraging doctors to participate in management and policy making?

30. How effective do you think your district has been in encouraging the involvement of senior nursing staff in management and policy making?

31. What difference do you think the reorganisation of management that follows the Griffiths inquiry will make to the *participation* of doctors?

32. What difference do you think the present reorganisation of management will make to the participation of senior nursing staff?

33. Who do you think has had the most influence in the new management arrangements being made in your district?

34. What role do you see for the health authority's members once the general management function has been implemented? What role did you think the health authority's members played in the formulation of units of management? What was the particular contribution of the health authority's members to the formulation of unit structures in 1982?