Risk, Trust and Governmentality: Setting priorities in the new NHS

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Abstract

The thesis explores priority setting in the National Health Service. It focuses on the changing way in which rationing issues are dealt with in the wake of the Health Service reforms and the separation of function between purchasing and providing health care. It examines how managers within sample District Health Authorities justify their priority-setting agenda.

Two connected themes are also analysed. One is how health needs assessment and the call for a 'primary care led NHS' presage a more dominant role for Public Health medicine in informing purchasing. Secondly, how evidence based medicine together with the use of clinical protocols/guidelines, measurement of outcomes and the use of clinical/medical audit, become factors in the decision making process.

Theoretically, the thesis attempts to demonstrate a practical use for the Foucauldian concept of 'governmentality' as a framework with which to analyse contemporary changes in health policy. The principal concern is the role experts play within the problematisation of government associated with liberalism. This includes their role within the institutions and technologies of governance that reflect the notion that the strength of the liberal state is derived from securing the well being of the population. In turn this reflects the self-critical dynamic within liberal problematisations of defining the legitimate boundaries of government responsibility in a society made up of autonomous individuals.

The PhD is based on semi-structured interviews (32 in total), conducted with the Chief Executives and principal directors of six English District Health Authorities, together with the Chief Officers of their associated CHCs. The District Health Authorities were selected - after a general review of Health Authority Purchasing Plans for 1996/97 - from those Authorities that acknowledged the rationing debate in their purchasing intentions and represented a cross-section of gainers and losers with respect to the new funding formula.

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Chapter 1

Setting priorities in the new NHS

Introduction

The aim of the thesis is to investigate the theoretical and empirical value of employing the conceptual framework of 'governmentality', associated with the French social theorist Michel Foucault, to analyse contemporary British health policy. Governmentality analysis situates social and economic change as reflecting shifts in the 'mentality' of government. The main focus of the thesis will be an analysis of health policy as it relates to the problem of governance of health care within liberal forms of governmentality. In particular, the thesis shows how the governmentality framework can be used to analyse how certain regulatory discourses and practices come to be institutionalised within the British National Health Service (NHS).

Empirical evidence in the form of interview data will be presented which illustrate how the NHS reforms of the 1980s and 1990s can be seen as part of a neo-liberal formula of governance which articulated a 'free market' rationale as the basis of social policy. The consequence of this new articulation is that the concepts of priority-setting and rationing become embedded as dominant discourses and emergent practices within health policy. One of the most important aspects of this is the way in which neo-liberal forms of health governance re-code and re-problematise the function of the health care system predominantly in terms of economics. This process of re-coding entails reinterpreting the provision of health care services within the NHS as historically a form of *implicit* rationing. The new health economics discourse presents a form of *explicit* rationing as a reasoned and ethical response to the contemporary problem of maximising the benefits of health care within limited resources. However, of equal importance is the way in which the perceived shift in the formula of governance also results in a different conceptualisation of the subject of health governance and creates a new relationship between bureaucratic control of the health system and regulatory medical expertise.

The NHS and health governance

Axiomatically, the NHS is an institutional solution to the problem of providing comprehensive health care for the British population. However, using 'governmentality analysis', it will be argued that the problematisation of health care for which the NHS became the preferred solution, is directly related to a particular discourse of welfare liberal governance that renders lived reality amenable to political calculation. In essence, the NHS is an institution which provides collective social insurance as part of the management of health care resources in a welfare state. However, there are inevitable consequences when the state becomes responsible for managing the collective health risks of the population. In doing so it implicitly engages in a discourse of health care governance which ultimately manifests itself in an political debate about the best use of health resources. Furthermore, it will be argued that one of the consequences of this discourse is that collective provision subjectifies the individual as a passive consumer of health care within a system dominated by the medical profession functioning as a form of regulatory expertise. The power of the autonomous medical profession within a welfare liberal form of health governance, it is suggested, results in limited bureaucratic control over the allocation of resources. Therefore, political control over the health care system often revolves around control and size of global budgets. The difficulty for government of this form of governance is that the inherent tension between bureaucratic control and medical professional expertise often makes itself apparent in terms of 'crisis' within the health care system.

The shift to a different form of liberal health governance can be seen as one consequence of the political difficulties caused by such recurrent 'crises' within welfarism. It is argued that the form of governance which ultimately sought to replace welfare liberalism reflected a neo-liberal economic discourse. One of the consequences of this new problematisation of governance was that it re-conceptualised the provision of health care in terms of an economic discourse. The problem of managing health care resources without the guidance of the 'invisible hand' of the market is therefore seen to express itself as a 'fundamentally moral or political problem' (Fleck 1994: 386). As patterns of services evolve within the health service the implication is that there are

continuous unconscious value judgements being made that mean that resources spent on some treatments or procedures produce more welfare than that derived from any alternative use of resources. This further implies that some individuals are valued more highly by society than others. Therefore, this moral question embedded in health care provision can only be addressed by a new understanding of priority-setting which incorporates a supposedly 'neutral' form of analysis.

Setting priorities for health care

The compromises agreed between the government and representatives of medical interests in order to get the NHS started in 1948, resulted in clinicians enjoying a very high degree of control over their conditions of employment and a great deal of influence over the production of health policy. One of the consequences of this high level of clinical autonomy is that, paradoxically, the main agents of rationing (when priority decisions are manifested in real decisions) are the medical professionals themselves. The development of the GP's 'gatekeeper' role into secondary care, along with clinical autonomy and waiting lists, have combined together to become the main mechanism of rationing in the NHS (Harrison 1995).

The NHS is not unique in being a state-funded and predominantly state-provided health care system, although it does occupy a position at the extreme end of the continuum between public and private (market) systems. But one of the consequences of this is that the problem of setting priorities becomes even more acute and is necessarily played out in the political arena. Indeed, as Klein et al. acutely observe, 'rationing is a word whose semantic origin evokes notions of reason but whose use often prompts unreason' (Klein et al. 1996: 7). The rationing/priority-setting debate is inclined to be emotional and confrontational, often not about the patterns of priorities themselves but about the size and adequacy of global budgets for health care.

The 'problem' of rationing or priority-setting is intrinsically an economic concept. In classical economic theory it is usually asserted that the interplay of supply and demand within a free market will tend towards an equilibrium position where resources will be

allocated equitably. However, the act of rationing or priority-setting of health care resources implies that there is no natural tendency to allocate resources justly. As the 1979 report of the Royal Commission on the NHS remarked:

> the demand for health care is always likely to outstrip supply and... the capacity of health services to absorb resources is almost unlimited. Choices have therefore to be made about the use of available funds and priorities have to be set (Royal Commission 1979: 51).

The clear implication of this statement is that the conventional means of bringing supply and demand into some semblance of equilibrium (ie the presence of a market in health care services), is not perceived as a solution to the problem of making difficult choices about priorities. The conventional wisdom is that the distribution of health care resources cannot be left to the market because medical care is inherently full of uncertainties (see Arrow 1963). It is impossible for individuals to know when they are going to be ill, or possess the expert knowledge necessary to calculate the potential severity of the illness or the likely costs incurred both in terms of treatment and loss of welfare that results. Furthermore, the practice of expert knowledge itself represents a problem for markets in health care services in that it is the source of asymmetries of information that could be exploited to produce monopoly control over the provision of health services. Additionally, the confusion over interests within a market dominated by health care expertise may be injurious to the doctor/patient relationship based on trust and expectations of altruistic behaviour (Le Grand 1986). Therefore, it is clear that there are a number of intrinsic problems associated with markets in health care which may ultimately lead to 'market failure'. When markets 'fail', the price of a good (in this instance health services) no longer carries sufficient information necessary for consumers to calculate any change in welfare as a result of consumption. The consequence of this is that any allocation of health resources that results will not necessarily meet health needs equitably. In effect, while free markets 'allocate' resources, other forms of distribution imply rationing or priority setting, either by price or as in the case of the NHS by some other (usually implicit) means.

However, since the 1970s, and particularly in the 1980s and 1990s, the question of setting priorities for health care spending has become an increasingly problematic issue

within the political regulation of the NHS. The command economy structure of the NHS was increasingly challenged by an economic and political doctrine that questioned the role of the welfare state within society. With the election in 1979 of a radical government that espoused a political doctrine based on neo-liberal economic theory, a search began for new 'market' solutions to problems previously thought not to be amenable to economic discourse. Increasingly the work of the health economist was seen to offer a technical solution to the problem of setting priorities within the NHS and to offer the prospect of 'de-politicising' the whole priorities issue. As Ashmore et al. (1989) observe:

> [Health economists] are collectively committed to making the economic practicalities of the NHS more rational and... their concept of rationality implies the need for greater uniformity of action throughout the system, more systematic appraisal of ends and means across the full range of economic decisions, a significant reduction in the influence of political factors within the system of health care, and the widespread use of allocative procedures designed in accordance with the basic concepts of economic theory (Ashmore et al. 1989: 36).

However, what was proposed by health economists was not a solution that would lead to the resolution of market failure - where rationing would be transformed into 'neutral' allocation. What was proposed was a 'rational' solution that would result in the health needs of the populations being met more efficiently and result in a more morally justifiable pattern of priorities. The political danger of this new economics rationale was that altering the *status quo* ran the risk that rationing, which hitherto was implicit and distanced the government from making hard choices, would become transformed into a much more explicit process. Thus, far from being value 'neutral' and apolitical, the whole process of making priority decisions would become intensely political and unstable. Furthermore, it is clear that a shift in the discourse in which the debate about health care takes place had a profound effect on other aspects of health governance. The new discourse changed the relationship between medical expertise and bureaucratic control which manifested itself in new forms of management structure. Equally important, the shift in the health discourse created a new conceptualisation of the relationship between the individual and health care governance

and hence a new set of subjects and categories for the health discourse. All of these issues can be usefully explored using 'governmentality analysis'.

The structure of the thesis

The thesis is divided into two parts. Part One consists of four theoretical chapters that explore the general theme of governmentality and related topics and establish it as an analytical framework that provides new insights into contemporary health and welfare policy. Part Two consists of three chapters which apply the analysis to the NHS, and present empirical evidence of 'post-reform' activity derived from case study interviews with District Health Authority directors and Chief Officers of Community Health Councils (CHCs).

The first chapter of Part One begins with a discussion of a well-established theoretical framework, namely post-Fordist analysis, which contests the same historical evidence as governmentality analysis. It is necessary and useful to review this approach in order to understand the value and distinction of Foucauldian framework used later. Therefore, there is a brief discussion of three 'schools' of post-Fordist analysis identified by Bagguley (1991), these are the 'regulationist' school which is associated with Aglietta (1979), the 'institutionalist' school represented by the work of Piore and Sabel (1984) and finally, the 'managerial' school or the 'flexible firm' thesis associated with Atkinson (1984) and Atkinson and Meager (1988). Of the various schools described most attention is paid to the Marxist inspired 'regulationist' variant of post-Fordist analysis. This is for two reasons: firstly, it is the least deterministic of the schools identified; and secondly it is associated with a body of work that explores the implications of post-Fordism for welfarism.

One of the leading theorists whose work is discussed is Jessop (1989, 1991 1992, 1994) and his concept of the 'Schumpeterian workfare state' (SWS) as a direct replacement for the Keynesian welfare state (KWS). A limited critique of the Jessop's work, and post-Fordist analysis in general, is presented on the grounds that it gives only a partial account of contemporary welfare state in that it fails to account for non-class relations. However, the main point of the chapter is to contrast post-Fordist

analysis with that of postmodernist forms of analysis (of which 'governmentality analysis' is an example) and to indicate that any investigation of contemporary NHS organisation and practices needs to be connected with broader explanations of welfare state restructuring. This is followed by a discussion about whether postmodern ideas can form the basis of a progressive critical politics if they reject the concept of 'universalism' (see Taylor-Gooby 1994; Mishra 1993; Fitzpatrick 1996; Hillyard and Watson 1996). The central difficulty revolves around questions of epistemology. The second part of the chapter deals with a critical appraisal by commentators such as Rorty (1986, 1992), Habermas (1985), Walzer 1986, Hoy (1986) and Dreyfus and Rabinow (1983, 1986) of Foucault's work as a leading postmodern/poststructuralist theorist. The final part of the chapter outlines Foucault's (1978) concept of 'governmentality'. This is accompanied by a discussion of governmentality by Gordon (1991), Burchell (1991), Pasquino (1991) who develop the concept of governmentality as applied to liberal mentalities of governance.

Chapter 3 examines the implications of Foucault's particular use of power by contrasting it with Robert Alford's (1975) influential account of policy formation within health care systems. Alford's concept of 'structural interests' is discussed and its relevance to the contemporary NHS debated; Alford's own use of power as manifested in competing structural interests is central to the chapter. A brief discussion of conventional approaches to power from Dahl (1957) to Lukes (1974) is contrasted with Foucault's notion that power is always implicated with knowledges - to form a power/knowledge discourse - that provides the categories that make non-discursive reality amenable to rational discourse. This idea is developed by Rose (1993) and Rose and Miller (1992) who describe the governance of health as a form of regulatory control of populations. Rose and Miller propose the idea of <u>expertise</u> as being central to regulatory regimes. This theme is further developed in chapter 4, which discusses the role medical expertise plays within liberal forms of health governance and the regulation of populations. In this chapter there is also a review of the professions literature and its compatibility with governmentality analysis, for example Freidson (1970, 1973, 1994), Larson (1995), Light (1995) and Johnson (1972, 1977, 1995). There is also a discussion of professional (medical) autonomy, the relationship of professions to the state and ideas such as deprofessionalisation (Haug 1975; Haug and

Lavin 1983; Starr 1982). The chapter ends by reviewing the debate about the developing techniques of audit and evidence based medicine (EBM) as technologies of management control (Mooney and Ryan 1992; Pollitt 1993; Kerrison et al. 1994).

Chapter 5 explores the concepts of implicit and explicit rationing/priority-setting policy within liberal forms of health governance. There is a discussion of 'market failure' when applied to the provision of health care (Le Grand 1982) and the problems of 'just' rationing policy (Fleck 1994; Daniels 1993). Klein et al. (1996) provide a classification of rationing strategies which is discussed and assessed. The following section considers the debate about the merits of implicit rationing strategies in the form of the classic 'tragic choice' formulation of Calabresi and Bobbit (1978). This is contrasted with the explicit priority setting rationale developed in the state of Oregon, USA (Buist 1992; Honigsbaum 1991), and the problems associated with central rules-based rationing processes (Mechanic 1992). Subsequent sections of the chapter examine emerging technologies of rationing such as the Quality Adjusted Life Year (QALY) and Quality of Well-Being (QWB) scales and their use within the new context of purchasing and assessing health needs associated with the NHS reform process initiated by the 1989 White Paper *Working for Patients.* Following on from this discussion there is an examination of how individuals have become the subject of the new health discourse. The new discourse demands a sort of 'prudentialism' (O'Malley 1992) of individuals, a self-management of personal risk. It is argued that in many respects this resembles the construction of the individual within classical economics - *homo economicus.* The last part of the chapter presents a critique by the American sociologist Mark Granovetter (1974, 1985, 1992) of works such as those by Becker (1976) and Williamson (1975) which present economic models of behaviour as the basis for explaining all social behaviour.

In Part Two of the thesis Chapter 6 seeks to place the development of the NHS within a governmentality theoretical framework. This chapter makes use of a common body of evidential material provided by established historical accounts of the development of NHS as an institution and its place within the formulation of health policy (see Klein 1995; Allsop 1995; Ham 1992; Mohan 1995; Stacey 1988; and Webster 1998). However, the use made of this historical data within governmentality analysis does lead

to a clear divergence with conventional accounts of policy formation. Governmentality analysis does seek to place the development of the NHS within an historical context yet does so without imposing a 'grand narrative' structure on the data. The potential problems for governmentality analysis in using periodisation as part of the description of NHS development (and the related difficulties connected with the concept of a policy process) are discussed in this chapter. The following two chapters, Chapters 7 and 8, present and analyse empirical evidence describing the role played by health authorities in commissioning health services to meet local health needs and the way in which new technologies of priority-setting shape the 'rationing' debate. Additionally, in Chapter 8 there is a discussion and analysis of the influence that different forms of consumer representation have over health authority commissioning decisions. These chapters both increase our knowledge about health authority and CHC activity and critically engage with previous research on the same topic, including Appleby (1994), Appleby et al. (1992), Barnes and Cox (1996), Freemantle and Harrison (1993), Ham (1980), Harrison and Wistow (1992), Flynn et al. (1997), Freemantle et al.. (1993), Redmayne et al (1993), Redmayne (1995), Klein et al (1996), Lupton et al. (1995) and Ranade (1995). The thesis concludes by arguing that governmentality analysis provides new understanding of the 'problem' of health care governance that hitherto have not been fully explored, and provides a conceptualisation of the contemporary rationing and priority-setting debate that reflects much more complex societal issues than conventional accounts of NHS development can accommodate.

Chapter 2

Theorising the Contemporary Welfare State

Introduction

Before considering the application of a 'governmentality' framework for analysing health policy, it is necessary to review a broader range of theories that concern themselves with developments in the welfare sate, and place them in some kind of context. The primary purpose of this chapter is, therefore, to outline some influential theoretical perspectives that seek to account for changes in contemporary Britain (especially in the sphere of welfare) and the welfare state and to prepare the theoretical ground for subsequent chapters. However, it is not in itself meant to be a comprehensive review of current thinking in this area. The more specific aim is to counterpoint the post-Fordist debate against postmodern ways of thinking, in other words, to compare and contrast a methodology that overtly relies on the logic of the grand or meta-narrative to give it its internal consistency, against a programme of investigation that specifically rejects such notions. The strategy behind this investigation is to explore whether abandoning the meta-narrative inevitably results in confusion and inertia, and more importantly ends in the jettisoning of positive 'universal' notions such as citizenship and the 'progressive' ideals at the heart of the Enlightenment experiment. A key issue for debate is whether postmodernist ideas are themselves a source of emancipatory politics by disrupting 'universal' categorisations that trap individuals within, and subject them to, the discipline of a coercive welfare discourse. Consideration of these questions is necessary in order to appreciate the purpose and value of the Foucauldian approach discussed later.

The end of the post-war consensus?

It is clear that Britain has experienced major changes in the last 30 years. The post-war boom of the 1950s and 1960s encapsulated in the certainties of the 'never had it so good' ethos, gave way to the doubt and pessimism of the 1970s. Rising commodity prices - especially the price of oil - rising unemployment, labour unrest and high

inflation coupled with low growth (so called 'stagflation'), seemed to herald a long-term international crisis in capitalist accumulation. In Britain, the post-war consensus on the welfare state was beginning to be questioned. The declaration by a Labour government that you could no longer spend their way out of recession appeared to signal that the bold experiment with Keynesian economics had failed. Indeed, Keynesian economics was perceived as part of the problem of maintaining economic stability, not the solution. Governments could no longer have faith in the macro-economic levers of power. Controlling demand no longer held out the promise of an escape from the vicissitudes of the economic cycle - only the prospect of double-digit inflation and deep economic recession. Perhaps as a result, in the late 1970s and early 1980s there was a reassertion of liberal, supply-side economics, and a retreat in direct state control in economic activity (see Hutton 1996).

In Britain, the election of a radical, overtly ideological Conservative government in 1979 appeared to reinforce this trend. The Thatcherite espousal of laissez-faire, neo-liberal, monetarist economics and the call for a new entrepreneurial spirit to be allowed to flourish, freed from the dead hand of the state, reshaped the political landscape. The strategy privileged liberty over equity, emphasising the rights of the individual at the expense of the collective. The 1980s saw a developing and ever-widening government programme wedded to the rhetoric of 'rolling back the state'. It seemed only a matter of time that the institutions of the welfare state, with its ever expanding budget, would be subject to the same forces of competition that had led to the privatisation model becoming the template for state controlled industries and other services. In housing, the council house tenants' 'Right to Buy' commitment was an early policy, together with the push to transfer the remit for the construction of social housing from local government and be given to Housing Action Trusts and housing associations. Policy initiatives in education and health came in the latter part of the 1980s with the 1988 Education Act and the 1989 White Paper *Working for Patients*. The emphasis was on consumer choice, and above all competition. In education this included greater parental right to choose their children's school, 'empowered' by the information contained in league tables that purported to monitor school standards. This expansion of 'choice', together with the right of some schools to 'opt-out' of Local Authority control (given parental approval), introduced a new dimension into education directly from the

discipline of the market with schools in effect having to market themselves in competition with neighbouring schools, with the tacit understanding that some 'failing' schools might not be able to attract enough pupils and would have to close. Similarly, one saw the same rhetoric of choice and competition employed in NHS reforms. For example, the *Patient's Charter*, created in November 1991 as part of the *Citizen's Charter* initiative, set out a number of 'rights' for NHS patients on waiting times and basic standards of quality in NHS facilities (DoH 1991). And more significantly, as part of *Working for Patients* (1989) it was proposed that to mimic the working of the market there should be a split in function between providers and purchasers which would create an internal or quasi-market. On the provider side there would be semi-independent, self-governing 'Trust' status for some hospital and community units financed through winning contracts to supply health care services. The most important purchasers would be restructured District Health Authorities, given the role of meeting local health needs, and in order to fulfil this role, placing contracts with appropriate providers - be they directly managed units, self-governing trusts or private suppliers. In addition, some General Practices would be able to opt for fundholding status and control their own budgets to purchase a range of hospital services for their patients. Taken as a whole with all the other welfare reforms, could it be argued that these the first stages of a 'recommodification' of the welfare state, the start of a new market in welfare services? Or are other processes at work? The question is - which are the most appropriate theoretical structures to make sense of these changes? The rest of this chapter explores some of these themes.

The transition to the Post-Fordist State

Some commentators have argued that there has been a fundamental change in the political economy of the welfare state in advanced capitalism. The theoretical framework that posits a transition from a 'Fordist' state structured around mass production and mass consumption, to a 'post-Fordist' state based on more 'flexible' ways of working and organisations, in many ways represents an archetypal grand narrative position (see Jessop 1989, 1991, 1992, 1994; Piore and Sabel 1984). It situates contemporary change within a holistic frame of reference, incorporating a historical perspective, that envisages a process exerting its influence across multiple

generations. The kernel of the different kinds of Post-Fordist theory (see Bagguley 1991), is to seek to comprehend the economic and social upheavals that came to a head in the 1970s in terms of a crisis within the prevailing regime of capitalist accumulation. As noted earlier, the resultant changes in political thinking and the rise of neo-liberal economics, especially in Britain, seemed to represent a reaction to a crisis that challenged the post-war political consensus at the heart of the Keynesian welfare state. It is postulated that a new regime of accumulation would entail significantly different patterns of individual and institutional consumption and production. The question being advanced, therefore, is if this was truly a crisis in the previous regime of accumulation, can one ascribe the shift to a neo-liberal form of economics as being characteristic of a new regime of accumulation? At face value the evidence does seem to suggest that a profound change had taken place. However, it could also be argued that using a framework that places so much stress on discontinuities will inevitably lead to the temptation of over-interpreting the empirical evidence, putting undue emphasis on the inevitable changes that take place in any society. But an even greater problem, even if one accepts that a transition has taken (or is taking) place, is to identify and disentangle those changes which are characteristic of the new regime from those which may be transitional and those that are part of an attempt to prop-up the failing previous regime. This is a daunting prospect for any researcher.

Fordism to Post-Fordism?

The basis of much thinking on post-Fordism is predicated to some extent on theories of long-waves of economic activity, particularly those of Schumpeter (1939, 1982). Building on the work in the 1920s of the Soviet economist Nicholai Kondratieff, who followed a broadly Marxist line, Schumpeter, and others such as Mensch (1979), perceived the cyclical aspect of long-waves as stemming from the bunching of technical innovations. At some point in the long-wave, economic possibilities would open up as the previous innovation cycle became exhausted and these could be exploited by entrepreneurs taking advantage of new more favourable conditions. The reality of these waves has often been questioned (see Kuznets 1940, on Schumpeter), but such theorising found a more receptive audience when predicted log-wave

downturns in the world economy appeared to anticipate the boom years of the 1950s and 1960s and the international crises of the 1970s (see Hall 1988: 57). This in turn stimulated new interest in theories that gave prominence to technological innovation as a dynamic for change, and these included those that sought to explain contemporary crises in terms of a shift from Fordist to post-Fordist technologies.

Bagguley (1991) identifies three schools of post-Fordism; the 'Regulationist school'; the 'Institutionalist school'; and the 'Managerial school'. Each incorporates a different set of dynamics for the transition to a post-Fordist state. The Fordist state is typically defined in terms of a system of mass production aligned with mass consumption, dependent on the assembly line production of standardised commodities with standardised labour processes, and underpinned by a Keynesian-style welfare state.

The **'regulationist'** school derived from a Marxist economic perspective, and associated with the work of Aglietta (1979), incorporates two inter-linked areas where the resolution of crises in capitalism can take place; the mass production/mass consumption based regime of capital accumulation and its associated socio-institutional structure, the mode of regulation. In this scheme, the crisis in capitalism in the 1970s was of an 'organic crisis' (Aglietta 1979: 385) within the 'Fordist' regime of capital accumulation as the rigidities inherent in the mass production processes and its associated division of labour limited the ability of capital to maintain profits. Therefore, in order for capitalism to resolve this crisis and restore profitability, the regime of accumulation has to be reshaped by making production more flexible, the labour market less rigid and new forms of consumption developed - neo-Fordism. New forms of management are also now needed to administer the new production processes and this is mirrored in new modes of state regulation, that include a welfare system more appropriate to the needs of the new regime of accumulation.

The **'Institutionalist'** school, represented in the work of Piore and Sabel (1984), is in many ways less deterministic about outcomes than the regulationists. For them the crisis in capitalism has a number of possible causes but principally it is seen as the result of structural problems in mass production leading to a mismatch between mass

production and mass consumption. Mass production, resulting in the saturation of the market in mass consumption goods, cannot respond to the demand for differentiated products as the market becomes fragmented thereby compromising profitability. The key to resolving this conflict is through new high technology production machinery, flexible enough to meet the different needs of the market as well as develop new niche markets.

The **'Managerial'** school and the 'flexible firm' thesis, associated with Atkinson (1984) and Atkinson and Meager (1988), emphasises the restructuring of the labour market around notions of core/periphery workers. In the new labour market, and to some extent as a consequence of the introduction of new technology, workers are valued for the degree of 'functional flexibility' they are able to exhibit. Therefore, the favoured few that possess the skills to adapt to new circumstances can enjoy a high degree of job security while the rest, dependent on the extent to which they can be easily replaced, at best have to make do with self-employment or short-term contracts, or for those at the outer edges of the periphery be subject to the uncertainties of 'hire and fire'.

It is clear from the nature of their arguments that, to some degree, all the above can be accused of determinism in one form or another. For Elam (1990), as noted by Williams (1994: 51-52), the problem of economic and technological determinism for the institutionalist and managerial schools respectively, places considerable limits on the viability of their theoretical frameworks. Only the regulationist school, he contends, is thought to have the versatility to account for a variety of economic, political and institutional influences because it can offer *two* areas where transformation can take place; in the regime of accumulation and in the mode of regulation. This leaves as 'unwritten' what a post-Fordist economy will resemble and what form and function the post-Fordist welfare state will take.

Post-Fordism and welfare

One of the best developed explorations of the implications post-Fordist ideas have for welfare is that of Jessop (1989, 1991, 1992, 1994) who works within the definition of post-Fordism advanced by the regulationist school. As noted above, the Marxist or neo-Marxist economic theorising which lies at the heart of the regulationist rationale, raises distinct problems of determinism. The reliance on the base/superstructure model does imply that in some way the economic circumstances of class relationships dominates, and that, in the last instance, the base of economic relations will circumscribe the possibilities of welfare reconstruction. Jessop himself neatly side-steps this argument by building into his model a high degree of discretion as to the nature and influence of the forces which may be at play in the transformation to a post-Fordist society. To illustrate this, Jessop outlines four dimensions that can be used to define Fordism and post-Fordism and where he argues the transformation will take place (see below):

1. the labour process considered as a particular configuration of the technical and social division of labour;
2. an accumulation regime, ie, a macro-economic regime sustaining growth in capitalist production and consumption;
3. a social mode of economic regulation, ie, an assembly of norms, institutions, organisational forms, social networks, and patterns of conduct which sustain and guide a given accumulation regime; and
4. a mode of societalisation, ie, a pattern of institutional integration and social cohesion which complements the dominant accumulation regime and its social mode of economic regulation and thereby secures the conditions for its dominance within the wider society.

(Jessop 1994: 14)

Using these dimensions one can examine the differences that Jessop expects to see with the transformation to a post-Fordist state (Figure 1).

The emphasis on flexibility is a characteristic of the other schools of post-Fordism outlined earlier. What is different is the introduction of the 'Schumpeterian workfare state', or SWS, as a direct replacement for the Keynesian welfare state (KWS) in the previous Fordist mode of regulation. To be even more precise, Jessop associates the

Figure 1 Key features of the Fordist and Post-Fordist state

	Fordism	Post-Fordism
labour process	mass production of complex consumer durables	flexible production process, flexible high-tech machines, flexible workforce
accumulation regime	balance of mass production and mass consumption	flexible and permanently innovative, new markets for differentiated goods
social mode of regulation	institutionalised collective bargaining and a Keynesian welfare state	supply side innovations; flatter, leaner organisational structures; 'Schumpeterian workfare state'
mode of societalisation	urban, 'middle-class', wage-earning society	unresolved

(based on Jessop 1994)

SWS with a 'hollowing out' of the state as power is dissipated and devolved to other institutions. As previously mentioned, using the base/superstructure model, the welfare state has to be seen in terms of its function in reinforcing and promoting the regime of accumulation. The key distinctions between the SWS and the Keynesian welfare state, are: the emphasis placed on the supply side of the economy as opposed to direct state intervention in managing demand, and the SWS's functions in underpinning the flexibility of the labour market and securing international competitiveness. As Jessop states:

> In this sense [the Schumpeterian workfare state] marks a clear break with the KWS as domestic full employment is de-prioritised in favour of international competitiveness and redistributive welfare rights take second place to a productivist re-ordering of social policy... In this sense its new functions would also seem to correspond to the emerging dynamic of world capitalism (Jessop 1994: 24).

It is self-evident that a SWS has severe consequences for those advocating ideas of 'universalist' welfare state (see Taylor-Gooby 1994, Offe 1994).The Keynesian welfare system is cast as the villain of the piece, part of the reason for the failure of the previous regime of accumulation. In this view notions of welfarism are couched in the rhetoric of limited government, so that welfare spending is seen as a 'burden' on the system, as unhelpful to labour flexibility and symptomatic of structural rigidities within

the economy that hinder supply side reform.

The fear is that the SWS, and post-Fordist analysis in general, may lead to the 'recommodification' of welfare with a blurring of the distinction between public and private forms of provision. As Bagguley (1994) describes:

> The recommodification strategy essentially reasserts labour-market discipline and re-introduces some kind of market rationality in the consumption of welfare services. Recommodification consists of cuts and sales. However, the structural and technical-economic limits to this strategy have lead to a shift in focus. This shift in focus has two principal dimensions. One, the development of market rationality in the internal organisation of state welfare, and two, the development of market rationality in the politics of welfare (Bagguley 1994: 77).

However, it has to be pointed out that not all post-Fordist analysis leads to such pessimistic conclusions. Sabel, for example, suggests that welfare responsibilities could, to a degree, be re-collectivised under the auspices of private industries, but with the consequence that the universal aspect of the welfare state may wither away to become a 'ramshackle version of itself' (Sabel 1994: 143). Even so, one has the feeling that Jessop's formulation of the 'hollowed-out' SWS has more intuitive credibility. However, given the high level of abstraction, it is prudent to heed Jessop's own warnings of the dangers of falling into the teleological trap of an *a priori* assumption of an emerging SWS, and allow the evidence to fall into the neat categorisations this produces. Jessop is at pains to point out the unfixed nature of the changes yet to take place. A great deal of negotiation has still to take place. As he states:

> Thus a more detailed analysis of the SWS would need to explore the structural coupling between each type of Fordism and the character of the nation-state and the problem this creates; the complexities of the capital relation in each regime type and its implications for the forms of economic and political struggle over crisis-resolution; the path dependency of the trajectory out of crisis which emerges in and through such struggles; and the problems that arise when the pre-SWS lacks the capacity to manage transition (Jessop 1994: 28).

Indeed this indeterminacy does lead one to question the suitability of a post-Fordist theoretical framework in accounting for actual empirical evidence. This is made more problematic in as much that contemporary change may be ascribed not to the post-Fordist state itself but to a transitional period that combines both a post-Fordist dynamic and the 'last gasp' efforts of the previous Fordist regime of accumulation to regain profitability. Historical distance is needed. As Jessop states, 'time alone is the test of whether a putative transitional regime will prove adequate to the alleged task. This indicates the need for *ex 'post'* analyses of how post-Fordist states emerge rather that *ex ante* (and therefore teleological) accounts of the necessary forms of transition to post-Fordism' (Jessop 1994: 22). Perhaps even more fundamentally, it is evident that much of the theorising around notions of post-Fordist transition centres on 'ideal types', based on discrete categorisations that encapsulate the essence of the theory, yet at the same time lead one to marginalise the complexities of real life situations. As Jessop himself points out, post-war Britain until the 1970s economic crises may not conform to the ideal type of a Fordist state, but something more akin to a 'flawed' form of Fordism. As Esping-Andersen (1990) suggests in his typology of countries by their welfare regimes - liberal, conservative, social democrat - Britain could be described as a 'mixed case', at the margins of the liberal category. So, returning to Jessop, what may be taking place might not be the transition from one ideal type (Fordism) to another ideal type (post-Fordism), but of a 'flawed' Fordism to a form of 'flawed' post-Fordism with all the complex contingencies that will involve.

Critique of the post-Fordist position

It is evident that we need to undertake a critique of post-Fordism. In this section there will be a continuation of the critical assessment of the post-Fordist debate in terms of two areas. Firstly, a limited return to the difficulties in dealing with 'ideal type' categorisations. And secondly, a discussion of the privileged role class relations play in post-Fordist theorising and the consequences this has for non-class divisions.

As was discussed above, post-Fordist analysis provides us with an interesting example of the problematic nature of dealing with 'ideal types' (see Cochrane 1991). Such theorising leaves the researcher wishing to use post-Fordist analysis in a dilemma. The

closer one adheres to the undiluted form of whatever post-Fordist formulation is thought to be appropriate, the easier it is in some ways to collect empirical evidence and allow it to fit the economic, institutional and social patterns the theory dictates. The problem, when the issue of complexity and contingency are pointed out, becomes one of justifying the validity of your arguments against the accusation that any discernible patterns are an artefact of the type of reasoning used. There is a possibility of seeing discontinuities where there may be none, marginalising inconsistencies that do not fit the pattern and neglecting other interpretations of the evidence. On the other hand, if one includes complexity in the argument, the problem now becomes one of interpretation. The smallest of contingencies may have a great impact on the particular trajectory of development. Conceivably, cause and effect may be impossible to discern and so become the subject of endless speculation that even detailed *ex post* investigation will not settle. One can look to long-wave theories themselves to see this process at work. The vast body of work generated over the last seventy or eighty years has failed to establish whether long waves are an actual phenomenon or not.

The second set of critiques explore areas that have direct consequences for the next part of this chapter. They revolve around the use of class relations as the basis of much of post-Fordist thinking. As was noted earlier in this chapter, the Marxist base/superstructure model that forms the bedrock of 'regulationist' school post-Fordist analysis, is predicated on economic class relationships. Moreover, it could be argued that economic relationships through links in production and consumption or changes in the labour market within manufacturing, also play a decisive role in other formulations of post-Fordism. However, the danger in giving so much prominence to the economic dimension is that it gives the appearance that all other aspects of social life are - maybe in the last instance - the epiphenomena of class relationships. This entails marginalising other dimensions of social life that give rise to the experience of women and ethnic minorities within and, importantly, outside the sphere of paid employment. As Williams argues:

> ... the conceptualisations of the welfare state, or welfare regimes, used in post-Fordist analyses are rooted in a white, male, able-bodied experience of welfare which ignores or marginalises the significance of other social relations. In particular, the relevance of social relations

other than class is ignored in relation to: the organisation of *paid* and *unpaid* work in welfare; the consumption of welfare; conflict and struggles over the distribution and delivery of welfare provision; the ideological content of welfare policies and practices; and the outcomes of welfare policies. In so far as issues of, say, gender or 'race', are brought in then they are either seen as the consequence of the organisation of welfare in relation to production or to class-capital relations, or they are subsumed under a more generic concept such as 'inner-city problems', 'underclass', 'New Social Movements', or 'family'. In particular rarely is the power of explanation or the power of agency granted to gender, 'race' or any social relation other than class (Williams 1994: 57).

As she further points out, such terms as core, periphery and skill are assumed to be gender-neutral (ibid.: 56) despite the volume of evidence to the contrary that has amassed over the years. The delineation of 'men's work' and 'women's work', and the definitions of skill which they embody, especially in manufacturing, are usually decided by male-dominated management or male-dominated trade unions, independently of their importance to the production process (see Cockburn 1983; Meegan 1988). In failing to take account of the non-class relations, post-Fordism neglects to notice these continuities in the experience of women and others, whilst overemphasising the discontinuities elsewhere.

Additionally, what is missing is an appreciation that all welfare regimes are in some ways gendered or have a 'race' dimension and this must be acknowledged by any theoretical framework that aspires to provide a comprehensive account of contemporary change. As Carter and Rayner point out:

> .... [A] social policy perspective would also seek to recognise the very different experiences of women (and ethnic minorities) within individual welfare periods - in both the public and private spheres. The welfare state as developed in the three decades following the Second World War - the Fordist welfare state - was itself a gendered settlement with regards to its founding assumptions, structures and day-to-day outcomes. Assumed differences about roles, life cycles and social horizons of men and women were so fundamental as to be the cornerstones of pension and benefit provision (and indeed major influences on other sectors such as education). The welfare state itself as an organisation and employer was similarly constructed upon a gender template (Carter and Rayner 1996: 357).

It would be no exaggeration to assert that welfare regimes can only function because of the gendered division of labour, 'that ensures that a large proportion of actual caring is delivered outside the public realm' (ibid.: 355), by women in the multiple role of mother - looking after children; daughter - caring for ageing parents; and partner - assuming responsibility for monitoring male health. Therefore, to concentrate on economic class relations is to fail to account for an important dimension of welfare, the unseen bulk of welfare activity that does not register in the formal economy, and which post-Fordist analysis conspicuously fails to address. As Carter and Rayner argue:

> Welfare then is an iterative and complex relationship with the economy and processes of accumulation. Similarly the 'welfare state' has always stood proxy for a variety of activities in the public and private realms. Unfortunately this richness and diversity is not captured by the rather blunt claim of a post-Fordist transformation (ibid.: 356).

The case for Postmodernism

The previous section outlined some important critiques of the post-Fordist position. In particular, it was noted that focusing almost exclusively on changes in economic relationships fails to recognise the significance in society of non-economic relationships. Although this was suggested in the context of post-Fordism and the supposed transition to a post-Fordist society, this form of critique can be extended to cover Fordist ideologies. One of the key concepts of which is the notion of 'universal' welfare. For many, as argued earlier, aspirations of universalism are central to notions of 'progressive' politics, even if in the extreme situations they are the 'least worst' option (Taylor-Gooby 1994, Offe 1994). The perceived danger must be that programmes that threaten universalism, are seen to threaten the progressive, aspirational politics in which the concept is embedded. However, by definition the all-encompassing nature of universal welfare leaves it open to a similar critique used on post-Fordism. The danger appears to be that individuals within 'progressive' welfare become subject to a discourse that institutionalises difference and hidden biases, thereby dis-empowering large sections of society. For example, if we take the 'recommodification' debate and reverse it to look at 'decommodification' - the

removal of a number of welfare services from market provision - we see a familiar set of critiques. If one takes the work of Esping-Andersen (1990), where it is argued that universal welfare rights, through 'decommodification', underpin social rights and enable political mobilisation, it has been argued that this does not take account of the gendered nature of welfare. Using a similar argument to that deployed against post-Fordism, it is argued that this kind of theorising neglects the largely unpaid role played by women as carers in the domestic setting. Decommodification could only be seen to enhance freedom for both sexes if the gendered roles in domestic labour and caring are overlooked (Williams 1994: 59). Williams goes on to highlight three areas where 'the rights of decommodification may not be extended fully to women': many women work part-time and are denied many full-time benefits; men may make claims based on the nature of their paid work, whereas for women access to benefits is through maternal or marital status; many allowances are based upon a gendered division of labour at home, especially around caring, denying benefits to those whose caring roles are deemed to be part of 'normal duties'. Expanding on this, Williams points out that:

> … the post-war welfare settlement depended upon women's unpaid caring work in the home (and to that extent welfare was never entirely state provided) and reinforced both this and their economic dependency. Furthermore the development of mass provision was also made possible through the availability of low-paid labour from the colonies and ex colonies. At the same time the 'universalism' of many of the post-war services and benefits was based on the norm of the white, British, heterosexual, able-bodied Fordist man, and often excluded women and black people upon whose paid and unpaid labour it depended. In different ways, in different industrialised countries a welfare settlement was struck according to a combination of a balance of class forces, the availability of cheap labour, cultural and political traditions and expectations which themselves were rooted in specific interrelations of capital, patriarchy and imperialism (Williams 1994: 61).

Thus there is a need to develop a theoretical understanding that on one hand can challenge the assumption that in different ways seem to underpin both post-Fordist and universalistic welfare, while at the same time still possess a sense of social justice and a dynamic emancipatory politics. The next section argues that some forms of postmodernist thinking supply such a theoretical framework that allows for greater

insight into the functioning of societies in transition than that provided by so-called 'progressive' theorising.

Postmodernism and 'progressive' politics

The relationship between postmodern thought and 'universalism', in one form or another, has provoked a great deal of debate (see Taylor-Gooby 1994; Mishra 1993; Fitzpatrick 1996; Hillyard and Watson 1996). It is often asserted that the adoption of postmodernist forms of thinking, and the explicit denial of the grand narrative, is a 'backwards step', limiting the development of a 'progressive' politics. For Taylor-Gooby, as mentioned earlier, any threat to 'universal' notions of welfare must by their nature be a retrograde step. And moreover, as Fitzpatrick observes, Taylor-Gooby insists that:

> postmodernist theory is largely blind to the increasing universality of economic liberalism. Its constructive role is limited, therefore. On the plus side, it stresses the individual and the group, as well as recognising the declining authority of the nation-state and the declining legitimacy of a centralised welfare state. But, on the negative side, it does not see the significance of economic fragmentation, labour market instability, inequality, privatisation and quango-run regulation (Fitzpatrick 1996: 305-306).

However, as Fitzpatrick (ibid.: 306) points out, Taylor-Gooby appears to have equated modernism with the Keynesian welfare state to produce an overly reductive interpretation of postmodernism. In this scheme of things, if postmodernism means the rejection of the modernist narrative, it must also entail a rejection of the welfare state, and by extension, positive and progressive politics, and vice versa. Furthermore, as Hillyard and Watson point out, Taylor-Gooby seems to misunderstand what is meant by postmodernism. Unlike Marxist or neo-Marxist theorising, for example, there are no core ideas to turn to, or a central body of work or a particular author. As they state, 'Taylor-Gooby falls into the trap that many commentators on postmodernism have fallen into before of using the term in a reified way - 'an 'it', if you like which 'does' or 'is' such and such' (Hillyard and Watson 1996: 322). When approaching such themes as the ubiquity of liberalism, postmodern thinking can engage with the 'reality' of its

effect on particular groups within society. However, at the same time, postmodern ideas emphasise that while such notions as economic liberalism aspire to be universal this impact is fragmented. There are categorisations embedded in its ideology that force individuals to become subject of a discourse. As Hillyard and Watson (1996) argue:

> Postmodernism has produced a vast array of literature drawing attention to the tyranny of the binary structuring of thought in modern society. In each binary opposition there is a hierarchical privileging of one side against the other. The discipline of social policy is replete with oppositions with one side carrying overtones of moral superiority: the abled and the dis-abled, the employed and the unemployed, the healthy and the sick, the depraved and the deprived, the criminal and the law abiding and home and work. Postmodern theory disrupts these categorisations arguing for an interconnectedness and a relatedness or for difference or fragmentation against structures based on division and domination (op. cit.: 323-324).

Looking back at the critique of concepts of universalism in welfare, and ideas surrounding decommodification, one can see these binary oppositions at work: paid and unpaid work; white and ethnic minority; the world of work and the domestic domain; full-time work and part-time work; 'men's work' and 'women's work'. In many ways the postmodernist emphasis on difference and fragmentation could form the basis of challenging these categorisations in a politics of resistance, analogous to a 'progressive' modernist politics. However what results is a specific, particular politics which in challenging categorisations cannot then try and replace them with something else. Postmodernism cannot with one voice deny the universal, yet at the same time cannot present anything to act as its replacement and present itself as an alternative universal discourse. As such there can be no 'progressive' agenda, an unambiguous political direction to follow. Without doubt this does represent a considerable break with the modernist politics.

Foucault, truth and power

For an influential alternative postmodern method of thinking one must turn to the body of work associated with the poststructural theorist Michel Foucault. It is central to his

argument that the individual is, in some way, created, categorised, and subjectified by the discourse in which they are implicated. In his works from *Madness and Civilisation* (1970) *The Birth of the Clinic* (1973) onwards, he seeks to develop the idea that societies have their own 'regimes of truth':

> … its 'general politics' of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true (Foucault 1985: 93).

For Foucault the truth 'is linked in a circular relation with systems of power which produce and sustain it, and to the effects of power which it induces and which extend it' (ibid.: 93). The product of this fusion of truth and power creates the bedrock on which fields of knowledge are constructed and which in turn provides the categories in which individuals become objects within that knowledge. Individuals become subjects of particular discourses but also subject to them. Additionally, the more knowledge the discourse requires about the individual the more the individual is subject to the discourse. Moreover, often it is the body of the individual itself which is the centre of the discourse, through medical science for example. Therefore these discursive regimes are in effect normative regimes, disciplining and regulating society, often through exercising power over the body (bio-politics), with the collection of information acting as a technology of surveillance.

Foucault appears to be specifically rejecting the Althusserian concept of 'interpellation', that individuals become subject to ideology through the function of networks of institutions, Ideological State Apparatuses (ISAs) (Althusser 1985). This is the idea that individuals unconsciously allow themselves to be subject to these ideologies because they feel themselves to be directly addressed by them and can comprehend themselves in terms of the 'reflection' provided by the ideology itself. For Foucault there is no need to invoke the concept of interpellation because 'power relations can materially penetrate the body in depth, without depending even on the mediation of the subject's own representations. If power takes hold in the body, this

isn't through its having first to be interiorised in the people's consciousness' (Foucault 1980: 196). For example, in his description of Bentham's concept of the 'Panopticon' one can see how in this more 'rational', less barbaric forms of punishment, part of a science of penology, it is the body of the prisoner that becomes the subject of the discourse, having to develop new behaviours appropriate to the new regime. The prisoner does not have to be in agreement with the rationale behind the incarceration strategy to be subject to it (Foucault 1979; also see Eckermann 1997: 156-157).

Foucault: methodologies and discontinuities

While the above does not misrepresent the broad thrust of Foucault's work it is illustrative of some of the profound problems one encounters in trying to make practical use of the Foucauldian 'opus'. At worst, it represents an eclectic approach, selecting concepts from different - and difficult - works and presenting them unqualified as part of a coherent whole. For example, the idea of the 'Panopticon', and by extension the model of society in which it is a central concept, comes from *Discipline and Punish* (1977), whereas the emphasis on the body as the focus of power and normalisation is more developed in Foucault's idea of 'bio-power' associated with later works such as *The History of Sexuality* (1981, 1985, 1986). In this instance there is a great deal of overlap in the arguments that underpin both these works, so the juxtaposition of these two concepts is not too egregious. However, such an approach fails to do justice to the variety and complexity of Foucault's task and more importantly, it exacerbates some of the difficulties inherent in Foucault's theorising.

One of the problems with understanding Foucault's work is Foucault himself. A prolific author of many books, articles, published lectures, interviews - both academic and non-academic, produced over several decades, this amounts to a vast body of work. Perhaps it is not surprising given the vastness of the output that there are subtle (and the not so subtle) shifts of emphasis developed in his work over the years. The more charitable of Foucault's interpreters deduce an almost evolutionary process at work, with a consistent set of central concepts continuously subject to dynamic analysis by a self-critical author of rare originality (see Dreyfus and Rabinow 1983;

Rochlitz 1992). Foucault himself did refer to his ongoing work as a 'slalom', or having foundations built on shifting ground (see Janicaud 1992: 292). However, many others are far less forgiving of the inconsistencies and contradictions they see in his work. For many, self-criticism smacks of vacillation, more akin to intellectual dilettantism, a product of 'infantile leftism' (Walzer 1986) or someone engaged in 'radical chic' polemics (Rorty 1986). The problem in part stems from a confusion of what role Foucault is fulfilling (presupposing that he has to be assigned to a particular role). Is he a historian as he sometimes professes to be? Does one try to engage his work from a philosophical perspective? Is he a social theorist constructing grand schemes? Or perhaps a more modest essayist? Or is he simply the product of a style particular to French academic philosophy? One which 'forbids you just to settle for being clever enough to have found interesting new descriptions to replace a boring old one', and instead insists they be part of a rigorous methodology, 'an illustration of a grand theory, the result of having adopted the right starting point' (Rorty 1986: 43). As a consequence of this uncertainty, a veritable industry has grown up interpreting and reinterpreting Foucault's work as well as adapting it to new fields of investigation (see Armstrong 1992; Burchell et al. 1991; Dreyfus and Rabinow 1983; Gordon 1981; Rabinow 1984). However, as one might have anticipated, this feverish activity has done little to quell charges of misrepresentation and confusion. The next section of this chapter discusses two of the most contentious areas of Foucault's work: the epistemological consequences of his methodologies and the impact this has on the possibility of Foucault's politics. The importance of this discussion is that it forces the researcher to examine the basis of Foucault's methods as a practical research programme.

Epistemology and the Archaeology of Knowledge

Foucault describes the 'archaeological' method in terms of the set of rules for certain historical periods which define a discursive space and which gives rise to discursive practices 'characterised by the delimitation of a field of objects, the definition of a legitimate perspective for the agent of knowledge, and the fixing of norms for the elaboration of concepts and theories. Thus, each discursive practice implies a play of prescriptions that designates its exclusion and choices' (Foucault 1977; cited in

Davidson 1986: 221-222). Therefore, historical investigation must go beyond the simple collection of historical texts. It must provide some understanding about the 'conditions of existence' of discourse (Foucault 1968; in Burchell et al 1991: 60). The 'set of rules which at a given period and for a given society', define and regulate the discursive domain in which things can be thought of as 'real' entities (ibid.: 59). In effect, the archaeology method seeks to uncover the conditions in which claims about what can be said to be true are made. What marks out Foucault's methodology as different from other forms of historical analysis is its openly anti-historicism, anti-Hegelian stance. Foucault states that he is not trying to 'question discourses about their silently intended meanings… or about the contents they may conceal' (ibid.: 60). As Rorty states, Foucault's methodology offers, at best:

> '… brilliant redescriptions of the past, supplemented by helpful hints on how to avoid being trapped by old historiographical assumptions. These hints consists largely in saying: do *not* look for progress or meaning in history; do *not* see history as a given activity, or any segment of culture, as the development of rationality or freedom; do *not* use any philosophical vocabulary to characterise the essence of such activity or the goal it serves; do *not* assume that the way this activity is presently conducted gives any clue to the goals it served in the past' (Rorty 1986: 47; author's emphasis).

It is not the intention to present a detailed critique of Foucault's epistemology, but discussion of it is relevant in as much as it impinges on the validity of Foucault's supposedly political pronouncements that are judged to have a moral or ethical dimension. These difficulties stem in part from Foucault's own pronouncements that he is not trying to create alternative epistemologies (see Foucault 1980; in Burchell et al 1991: 85; Rorty 1986). However, it is also clear that such early works as *The Archaeology of Knowledge* (1972) and *The Order of Things* (1971) do contain elements of reasoning than can be interpreted as making truth claims - if of the second-order kind. And while Foucault himself, as noted above, does not make such claims, others have suggested that the archaeology method can form a basis for a new epistemology (see Hacking 1979). Such positions can be sustained because the archaeology method does appears to owe a great deal to a kind of quasi-structuralism, in that 'things attain to significance in so far as they are able to form the elements of a

signifying system' (Foucault 1970: 382). However, although it should be noted that Foucault considered his method to be resolutely anti-structuralist (see Foucault 1984: 56), the parallels with normative rule-based use of language are self-evident. The method clearly suggests that the discourses in which individuals are embedded, and from which they derive subjectivity, can be uncovered. Any methodology which claims to be able to reveal the workings of the normative regimes within discourses appears to be making truth claims analogous to the claim that uncovering the structure of language allows one to say meaningful things about how language is used to describe the world.

However, there are great difficulties associated with this way of thinking. The most prominent one is the charge of relativism. Given that individuals are subjectified by discourse and that discourses change over time - hence the need for an 'archaeological' method - then any truth claims made by individuals are only made relative to the particular historical discourse in which they are situated. This leads to two major problems. Firstly, the methodology will privilege discontinuity over continuity. Secondly, if an individual is subject to a discourse which encompasses and regulates the totality of lived experience then how do discourses change over time? The methodology says nothing about how these changes may come about. Even more importantly - using an argument often levelled at relativistic forms of reasoning - a researcher methodically and painstakingly sifting the historical evidence is as subject to a historical discourse as anyone else. Meaningful discussion of past discourses is only possible by transcending all discourses which, by its own reasoning, is not possible. As Hoy argues:

> As supposedly true descriptions of past discourses, the archaeologist's own utterances have to except themselves from this relativity, producing Foucault's contradictory attitude as he shifts from the stance of the disinterested, objective historian to that of the partisan, engaged social critic. The archaeologist cannot criticise either past or present discourses by appealing to truth or falsity. Archaeology is designed to avoid the Whiggish assumption of the necessary superiority of later theories (for instance, our own) over earlier ones (Hoy 1986: 5-6).

Thus, as Hoy suggests, Foucault finds himself in a contradictory position. The archaeological method allows him to lay bare the normative regimes of truth that are embedded in discourses but at the same time the method robs him of the ability to compare how 'good' or ethical these regimes are because he is denied any external yard sticks by which to judge them. In a partial answer to these criticisms Foucault's later works, for example *Discipline and Punish*, employ a variation on the archaeology theme, using the method of 'genealogy'. However, as can be seen in the next section, while the new methodology answers some of the criticisms outlined above, many of the same fundamental problems remain.

Genealogy and Foucault's politics

The 'genealogy' method represents a subtle shift in Foucault's thinking. Whereas archaeology is preoccupied with examining discourses, 'genealogy' is more interested in how power and discourse interact to produce power/knowledge, ie. that which gives meaning to social practices and to the institutions in which they operate. Therefore, unlike archaeology, by focusing on the power/knowledge discourse genealogy *can* map gradual changes that do take place in rationality and meaning over time. However, like archaeology, the genealogy method is not concerned with grounding itself within a search for origins. As Foucault states:

> Genealogy does not pretend to go back in time to restore an unbroken continuity that operates beyond the dispersion of forgotten things; its duty is not to demonstrate that the past actively exists in the present, that it continues secretly to animate the present, having imposed a predetermined form on all its vicissitudes. Genealogy does not resemble the evolution of a species and does not map the destiny of a people. On the contrary, to follow the complex course of descent is to maintain passing event in the proper dispersion; it is to identify the accidents, the minute deviations - or conversely, the complete reversal - the errors, the false appraisals, and the faulty calculations that gave birth to those things that continue to exist and have value for us; it is to discover that truth or being does not lie at the root of what we know and what we are, but the exteriority of accidents (Foucault 1984: 81).

One of the strengths of genealogy is that the historian/researcher accepts they are as subject to power/knowledge discourses as everyone else. As Hoy suggests, this opens

up the possibility immanent social criticism. 'As a genealogist Foucault is able to diagnose the organizing trends of our culture only because he, too, is subjected to them' (Hoy 1986: 13-14). However, even though this form of critique does not rely on being independent of the current power/knowledge discourse (and so be subject to the criticisms offered against archaeology), it does seem to imply two things: the ability to view the present from the privileged vantage point of a fictitious future not granted to other mere mortals; or that discourse is not as totalising as it was assumed.

In part these problems are due to the 'post-structural' position inherent in the genealogy method. Genealogy does not lay claims of uncovering the truth or of any essentialism for the method itself, which was the charge against archaeology (or by extension the position of rule-based language in structural linguistics). Discourses become free-floating, with no correspondence to any external reality. In many ways this is a similar position to that described earlier when discussing the archaeological method, except this time we have to look at the problem from the other way around. Previously it was argued that the epistemological problems associated with the archaeology method denied the historian/researcher the basis for critical political comment. With genealogy (because it opens up the possibility for political action), it is the lack of any external reference points which leads to the same charge - that any political stance must be nihilist or anarchist in nature (Walzer 1986; Glücksmann 1992). This is exacerbated by Foucault's position on power. In traditional theorising about power relations (be it derived form Marx, liberalism or other kinds of modernist thinking), knowledge and power are separate entities, knowledge is part of the power dynamic in which one group or class exercises power over other groups or classes in suppressing their conscious or unconscious 'real' interests. But because Foucault denies discourse any external reference points, power becomes fused with knowledge to create the concept of power/knowledge. Genealogy becomes the method of charting the changing nature of this discourse which makes 'reality' meaningful. Ironically, this knowledge becomes 'unknowable'. So 'real' cannot be assumed to have any tangible reality as a concept. It is power without a subject. Power/knowledge creates fields of power that simply exist, they are inescapable, so attempting to extricate oneself from one set of power relationships only involves one being subject to a different set.

The new question that now arises is how can one know if a particular power/knowledge discourse is any 'better' than any other alternative power/knowledge discourse? This is the charge levelled against Foucault in Nancy Fraser's often cited set of questions:

> Why is struggle preferable to submission? Why ought domination to be resisted? Only with the introduction of normative notions of some kind could Foucault begin to answer this question. Only with the introduction of normative notions could he begin to tell us what is wrong with the modern power/knowledge regime and why we should oppose it (Fraser 1981: 238).

In essence, this forms the basis of the critique of Foucault presented by the leading theorist Jürgen Habermas (1985). Clearly Foucault's own ideas do not allow for Habermas's own formulation of the 'ideal speech community' - a normative counterfactual whereby one could envisage a 'rational consensus' brought about by the free, undistorted critical dialogue of competent individuals. However, what is more important is not that this particular formulation is rejected, but that Foucault denies all attempts of external validation of truth claims. Without this 'normative yardstick' critique is not possible. Therefore, Foucault is dubbed an 'irrationalist'.

Similar arguments are used in the critique of Foucault employed by Michel Walzer, irritated by 'Foucault the polemicist' who, paradoxically, deliberately denies himself a directing centre yet seems to engage in radical politics. In his own defence, Foucault often stated that he did not like to get involved in polemics (Foucault 1984: 381), or that his work was <u>not</u> part of a 'political project' (ibid.: 375). That is not say Foucault was not a radical. However, as Janicaud is at pains to point out, Foucault was at pains to separate his own militancy from the 'scientific nature of his work' and that 'one would seek in vain any militancy in *The Archaeology of Knowledge*, in The *Order of Discourse*, or even in *The Order of Things*' (Janicaud 1992: 291). For Walzer even the possibility of militancy or radicalism is at odds with Foucault's own methodology. For Foucault 'there would appear to be no independent standpoint, no possibility for the development of critical principles' (ibid.: 64). So that ultimately Foucault's

antidisciplinarian politics degenerates into 'mostly rhetoric and posturing' (ibid.: 65). Furthermore, because of the stress Foucault places on the role of discipline within Western capitalism, Walzer describes Foucault as a functionalist of the more pessimistic kind, relying on an invisible hand that leads Foucault to wonder how such a complex system, 'given that no one person could have conceived it in its entirety, ... can be so subtle in its distribution, its mechanisms, reciprocal controls and adjustments' (Foucault 1980: 62).

This pessimistic reading of Foucault is possible for many of his works. For example *Discipline and Punish* does extend the carceral regime beyond the prison gates to become a model for a carceral society. As Foucault suggests, 'why should we be surprised if prisons resemble factories, schools, barracks and hospitals. All of which resemble prisons' (Foucault 1977: 228). There is a feeling that individuals trapped in these disciplinary discourse are ciphers, docile bodies - beings with socially constructed bodies - 'bodies-without-organs' of the type associated with Deleuze and Guattari (1984; 1988), subjectified and 'totally imprinted by discourse' (Butler 1990). Walzer's reading of Foucault is that to resist a disciplinary regime only results in being enmeshed in another regime of power with no yardstick to compare which regimes is 'better'. Therefore, Foucault, he argues, is implying that all power systems must be abolished. As Walzer states:

> 'And so Foucault's radical abolitionism, if it is serious, is not anarchist so much as nihilist. For on his own arguments, either there will be nothing left at all, nothing visibly human; or new codes and disciplines will be produced, and Foucault gives us no reason to expect that these will be any better that the ones we now live with. Nor, for that matter, does he give us any way of knowing what "better" might mean' (Walzer 1986: 61).

In effect, what Walzer appears to be arguing is that if there seems no way of distinguishing between the 'carceral society' and the evil of the 'Gulag society', what hope is there of any progressive politics? Another problem lies in assuming that the carceral society is an artefact of modernist ways of thinking. That 'a subtle, calculated technology of subjection' (Foucault 1984: 210) is necessary for modern capitalism to flourish. Therefore, the implication would be that if Foucault's work is a warning

against the dangerous technologies of subjection inherent in capitalism then he seems to be presenting a case against modernism or is at least against the Enlightenment experiment. This is a difficult problem. If modernism and the Enlightenment as they are conventionally seen, represent the possibility of movement towards a moral end-point (or at least the presumption of an end-point for society to aspire even if it is not realisable), then the honest answer would be that Foucault is anti-Enlightenment. It is evident that many more critical commentators would be willing to level the charge that Foucault is anti-modernism/anti-Enlightenment, but at the same time suspect that Foucault cannot help but employ some unannounced moral or ethical standpoint (hence the charge by Habermas that Foucault is a 'crypto-normalist'; see Habermas 1985; also see Taylor 1986; Walzer 1986). Therefore, if Foucault were to be consistent and deny himself a moral yardstick, then his politics must inevitably be dubbed nihilist.

Foucault and nihilism

The question now becomes one of asking whether nihilism is in any way compatible with modernist or enlightenment thinking? The most obvious answer is a resounding no. Yet it has been argued that Foucault does present us with a new form of nihilism, one capable of sustaining 'the conditions of moral action' (Glücksmann 1992: 339; and Veyne 1992). This is a difficult trick to pull off but it clear in his last few works Foucault was trying to reposition himself as a thinker in the enlightenment tradition. In one of his last works *What is Enlightenment?* (1984), Foucault returns to re-analyse Kant's own 1784 essay of the same title. This is ironic given that a critique of Kant was the spur for the production of *The Order of Things* (see Hoy 1986: 21-22). Coming full circle, Foucault argues that modernity, postmodernity or whatever label is given to a particular epoch, do not refer to periods of history punctuated by discontinuity, but rather they are characterised by 'attitudes', by which he means:

> …a mode of contemporary reality; a voluntary choice made by certain people; in the end, a way of thinking and feeling; a way, too, of acting and behaving that at one and the same time marks a relation of belonging and presents itself as a task. A bit, no doubt, like what the Greeks called *ethos* (Foucault 1984: 39).

The use of the notion of ethos present the opportunity of breaking free of the 'blackmail' of being 'for or against' the Enlightenment. Foucault advances the view that as 'beings who are historically determined, to some extent, by the Enlightenment' that analysis of ourselves should be directed towards testing 'the "contemporary limits of necessity", that is, towards what is not or is no longer indispensable for the continuation of ourselves as autonomous subjects' (ibid.: 43). What Foucault seems to be saying is that the Enlightenment experiment cannot be reduced to a search for an "essential kernel of rationality" (ibid.: 43), but that the Enlightenment tradition is the embodiment of the principle of 'permanent critique of our historical era' (ibid.: 42). It is through the genealogy method that the critique is realised, rationalities questioned and categories disrupted. As Hoy points out, this has much in common with arguments advanced by Adorno and Horkheimer in *The Dialectic of Enlightenment*, that the 'pious belief in the unqualified value of enlightenment contradicts the enlightenment's own aspiration for rational autonomy' (Hoy 1986: 22). It is through the evocation of 'permanent critique' that Foucault can square the circle of uniting his own perceived nihilism with the tradition that has fuelled West thinking for the last two and a half centuries.

Foucault the poet?

It is not the function of this chapter to judge how successful Foucault is in performing this philosophical sleight of hand so that he can align himself with the Enlightenment project. It is clear that his claim to be included in the Enlightenment tradition has to be approached with scepticism coming from a man who seemed intent on undermining it for most of his working life. However, scepticism is one thing, to dismiss Foucault as 'flawed, but interesting' because of it is quite another. This is the equivalent of presenting Foucault's work as a necessary philosophical irritant, albeit 'rhetorically inflated and drained of moral distinctions, it never the less captures something of the reality of contemporary society' (Walzer 1986: 53). One way of rescuing Foucault from this damnation by faint praise is to point out that, above all else, Foucault was not concerned with epistemology but with methodology. Therefore, the problem becomes not one of Foucault's moral standpoint, or lack of it, but the standpoint of those that

make use of Foucault's work, in particular the use of his genealogy methodology as the basis of a research agenda.

Rorty (1992) presents Foucault as someone who 'wanted to do good to his fellow humans while at the same time having an identity which had nothing what so ever to do with them. He wanted to help people without taking their vocabulary as the one in which he spoke to himself. He wanted to help them while inventing a self which had nothing much (indeed, as little as possible) to do with theirs' (Rorty 1992: 321). The implication is that the Foucauldian ethic is a totally personal one. Foucault tries to do good for fellow human beings in his own terms, if this happens to correspond with doing 'good' within universalistic concept of that notion then so be it. Hence the suspicion 'that whilst being so wicked in theory (being so anti-universalist, so relativist, so opportunist), he was so good in practice (militating on behalf of prisoners, the mad and so on)' (Miller 1992: 258), and that Foucault was acting in accordance with some unconscious or unstated general principles. But as we will now never know, perhaps Foucault can be given the benefit of the doubt. So, as Rorty goes on to suggest, we may not be dealing with Foucault the philosopher, a dealer in aporias, but with Foucault the poet:

> For philosophers, as opposed to poets, are traditionally supposed to offer a 'basis' for our moral obligations to others. They are supposed to have what Fraser calls 'an adequate normative perspective'. Unlike poets, philosophers are supposed to a 'rational', and rationality is supposed to consist in being able to exhibit the 'universal validity' of one's position. Foucault, like Nietzsche, was a philosopher who claimed a poet's privileges. One of these privileges is to rejoin 'What has universal validity to do with me?' I think that philosophers are as entitled to this privilege as poets, so I think this rejoinder sufficient (Rorty 1992: 333).

However, can the work of a 'poet' form the basis of theoretical approaches to empirical research? Are there circumstances that make this possible? Even though Foucault's analysis is most coherent when it constructs his own private universe, with no intention of establishing alternative models of society, it could be argued that Foucault's methodology is an important *heuristic* device alerting us to 'contemporary danger' (Dreyfus and Rabinow 1986: 118). This becomes possible because Foucault, as

Hoy puts it, 'paints a picture of a totally normalised society, not because he believes our present society is one, but because he hopes we will find the picture threatening' (Hoy 1986: 14). However, it is evident that in presenting social discourse as partial and not totalising, individuals can no longer be seen as docile bodies 'imprinted by discourse' as suggested earlier, rather they must be autonomous reflexive individuals, capable of resistance. These are not the individuals that inhabit Foucault's earlier works, or even 'genealogical' works such as *Discipline and Punish*. But this reformulation of the autonomous individual is characteristic of Foucault's very last works. This was demonstrated above in Foucault's commentary on Kant, *What is Enlightenment?*, but it is also present in *The History of Sexuality* and his work on 'governmentality' - a discussion on the 'art of government'.

But where is the space for individuals to be reflexive and autonomous within Foucault's theorising? Is this space outside discourse in some way? Again we return to the charge that Foucault is being disingenuous by creating some sort of essentialist position beyond the reaches of discourse. One can avoid this by taking refuge in the notion that discourses are always partial, only seeking to make limited sense of the mass of reality which is by its nature non-discursive. Although discourses may be presented as totalising by those whose power is legitimised by them, the reality is that there is always a gap, a 'non-discursive "residue" [which] enables resistance to power/knowledge, no doubt providing a resource to the reflexive self as it is inscribed by discourse' (Fox 1997: 44). In a form that resembles the theory of 'structuration' associated with Anthony Giddens (1979), it is suggested that this non-discursive 'residue' can be the site of reflexivity and resistance because it gives space for alternative discourses to exist. The constant friction between the presentation of discourses based on supposedly universal truths and the contingencies of everyday life creates the possibility of alternative social categorisations developing as the basis for the production of 'counter discourses' and resistance to the dominance of a particular power/knowledge regime.

We are still left with the problem that if the counter-discourses becomes themselves dominant, what criteria are there to decide if it is any 'better' that the one it replaced. We seem to be going round in circles. As Hacking notes, even two of Foucault's

staunchest supporters, Dreyfus and Rabinow, sense that Foucault 'owes us a criterion of what makes one kind of danger more dangerous that another' (Dreyfus and Rabinow 1983: 264, cited in Hacking 1986: 238). But now that discourses are seen to be inhabited by reflexive, autonomous individuals at least there is some possibility of rectifying the situation.

Governmentality

As mentioned above, one area of Foucault's later work which employs this less pessimistic view of the individual is his analysis of 'governmentality'. Foucault defined governmentality three ways as either: the 'institutions, procedures, analyses and reflections, the calculations and tactics' that support a particular rationale of power and apparatuses of security, with populations as their target; or the tendency of this type of power becoming pre-eminent in the West resulting in 'the formation of a whole series of governmental apparatuses... and in the development in a whole series of *saviors*'; or the historical process since the Middle Ages whereby the state of justice become 'governmentalised' (Foucault 1978: in Burchell et al. 1991) At its most basic governmentality can be see as the extension of Foucault's methodologies into the arena of state theory. As Gordon states, for Foucault '[t]here was no methodological or material discontinuity between the respective, micro-physical and macro-physical approaches to the study of power' (Gordon 1991: 4). In effect, governmentality links the techniques of discipline and control of individual living bodies (bio-politics) directly to state policies. However, unlike more traditional forms of analysis of state power, governmentality shifts the focus of interest from the institutions towards the *practices* of government. These practices are in turn directly related to, and are legitimised by, a 'rationale of government'. The difference between this and similar concepts such as the Gramscian notion of 'hegemony', is again the idea that power/knowledge regimes produce fields of power which are simply *there*, and cannot be reduced to serving the interests of one group or another (see Smart 1986). Therefore, government is as much a product of a discourse as the individuals are subjectified by it. The state becomes a fiction, the central idea of sovereignty part of the rationale of government. Government becomes defined in terms of the 'conduct of conduct', as 'a form of activity aiming to shape, guide or affect the conduct of some person or persons' (Gordon 1991: 2).

For Foucault the greatest flowering of discourses about the 'art of governance' comes with the rise of liberalism in the eighteenth century (Foucault 1978: in Burchell et al. 1991). This contrasted with earlier concepts of government, in particular those elaborated in such works as Macchiavelli's *The Prince* - where government is seen in terms of the rational means of protecting the integrity physical of the state, a *raison d'état*. In turn, the early modern formula of government set out in *The Prince* is contrasted with the 'cameralist' or 'police' states in the German speaking territories after the Thirty Years War where government is directed at establishing order. In *The Prince* legitimacy is essentially imposed on the state, and government reflects this. In the 'police' state governmental legitimacy derives from its ability to establish order through an administrative rationale. The difference between this and Macchiavellian concepts is that the prime concern of government is not the physical integrity of territory but the 'happiness' of the population (see Pasquino 1991). The strength of the state is identified with the well-being of the population and the proper functioning of the mercantile economy. But to do this the government must actively and continuously seek to have knowledge of the population. The more the state can generate knowledge of individual circumstances the more it can intervene to maximise general prosperity. The dynamic becomes circular: state governance guarantees order, order allow individuals to flourish, happy individuals guarantee the strength of the state. It is the nature of government in the 'police' state to not just intervene in state activity but to *continuously* intervene. Although the 'science of police' generates the first modern system of economic sovereignty, 'of government understood as an economy', it has no autonomous rationality. The consequence being that '[t]he economy of a functioning whole is a machine which has to be continuously made and not merely operated, by government'(Gordon 1991: 11). This forms a crucial distinction between the 'police' and liberal states.

In liberal forms of governmentality the political economy is considered to be autonomous, guided by the invisible hand so eloquently described in the works of Adam Smith. Although this seems a minor change in the formula of governmentality, the repercussions are considerable. The invisible, and unknowable, hand that regulates the political economy is based on the actions of the autonomous enlightened

individuals in the pursuit of their own self interest. Most importantly, it is through this process of regulation that order is created. It does not have to be guaranteed by the state because order is considered to be the natural state of things - individuals free of the fetters of autocratic government would flourish and live in harmony with his neighbours (as opposed to Hobbesian notions that free from all constraints life would be 'nasty, brutish, and short'). The autonomous individual becomes self-regulating and discipline becomes internalised. The consequences for the state are also profound. The state no longer derives legitimacy through the guarantee of order. Unlike the 'police' state, there is no need to continuously remake the machinery of economic regulation. The role of state is that of the caretaker providing routine maintenance. However, the 'strength of the state' is still situated in the happiness of the population. It is the government's principal role to guarantee 'life, liberty and the pursuit of happiness', to coin a phrase. This results in a dilemma for liberal governments. On one hand, the role government is predicated on minimum intervention in the political economy to provide as much freedom for individuals to make their own choices - the classic formula of 'negative' freedom. On the other hand, there is a pressure on governments to pursue maximum welfare by actively intervening in society to ameliorate inherent social disadvantages for some sections of the population - so called 'positive' freedom.

Therefore, the Western 'art' of liberal government is a dynamic, self-critical process. The parallels with Foucault's musings on the meaning of the Enlightenment are quite clear. The strength of the liberal form of governmentality is that it is essentially a process of critical problematisation of the nature of government. The central dynamic is the tension between minimum government and a 'will to knowledge' about populations - multiplying the categories which individuals are subjected to and subjectified by, in the pursuit of the most efficient form of government, underpinned by the rationale of a particular power/knowledge regime. The power of governmentality is that it allows the investigation of different aspects of liberal forms of government as essentially different aspects of the problematisation of power (see Rose and Miller 1992; Rose 1993). As Rose argues, historically different forms of liberalism should not be understood as 'periodisation':

'Rather, they are an inevitable schematic way of identifying a number of distinct - if not sharply delineated or mutually exclusive - problematizations of rule: ways of asking what should be ruled, by whom and through what procedures. It is these problematizations that accord the activity of politics its intelligibility and possibility at different times; it is these problematizations that shape what are to be counted as problems, what as failures and what as solutions' (Rose 1993: 285)

The value of Rose and others' work is that it opens up the study of liberal policy making, government rationality and the management of populations to new ways of thinking. However, the difference between this and traditional policy studies is the notion that liberal conceptions of government and population are not fixed but are the product of changing power/knowledge discourses in which they are embedded. The critical dynamic at its heart is the dilemma 'of not governing enough versus the fear of governing too much' (ibid.: 292).

Conclusion

The aim of this chapter was to review several recent influential theoretical approaches to the welfare state and introduce governmentality as a useful analytical framework and practical methodology that could account for changes in contemporary welfare policy. The device employed in the chapter was to compare governmentality analysis - incorporating Foucault's concept of 'genealogy' - as an example of postmodern or post-structuralist theory, with an alternative and influential framework, post-Fordist analysis, which also portrays changes in welfarism as resulting from a shift in the regulatory regime. The value of the post-Fordist comparison is that it is an example of a type of analysis that relies for its internal coherence on a grand or meta-narrative. In comparison, postmodernism (and governmentality analysis) rejects the grand narrative framework but without providing an alternative to put in its place. The debate is whether this also means the rejection of 'progressive' critical politics. There is no attempt to provide an answer to this problem, except to point out that Foucault does provide the basis for a personal politics if not universal one. However, this does not detract from the argument that governmentality is a practical methodology for providing a means of investigating the discursive space which 'renders reality thinkable in such a way that it is amenable to political deliberation' (Rose and Miller 1992: 179).

The governmentality framework is essentially a 'heuristic device' for producing new insights into the policy making process. The next chapter makes use of the work of Rose and Miller and the governmentality framework to investigate the production of health policy and the role of 'expertise' within formulas of liberal governance. This is contrasted with other accounts of the health policy process, in particular that described in the work of Robert Alford (1975) and his concept of 'structural interests' within health care systems.

Chapter 3

Governmentality and risk: health care and the re-problematisation of governance

Introduction

It is clear from the previous chapter that Foucault's concept of governmentality causes considerable problems for traditional ways of analysing the role of government. In particular, it is his specific formulation of how power is exercised that disrupts notions such as freedom, individuality and ideology. Foucault states directly that his work 'has not been to analyse the phenomenon of power, nor to elaborate the foundations of such an analysis... [but] to create a history of the different modes by which, in our culture, human beings are made subject' (Foucault 1983: 208). Therefore, governmentality is not a methodology for identifying those individuals, groups or institutions who somehow *possess* power over others, but is an attempt to understand how a power/knowledge discourse underpins the technologies of government that legitimise those power relationships. Governmentality is the investigation of the discursive space that allows lived reality to become amenable to political deliberation. In the case of liberal formulas of governmentality, this discourse reveals a reflexive problematisation of the nature of government - its scope and its limits - that includes those who exercise power as much as those subject to it. Formal governmental structures become the temporary reification of the particular formulations of this problematised space.

The purpose of this chapter is to use ideas of governmentality as advanced by Foucault and others to explore, at the meso level of analysis, the production of health policy and to account for contemporary changes in policy connected with the British NHS. The first part of the chapter will compare 'governmentality' analysis with a well-established theoretical framework for health policy analysis, namely that associated with Robert Alford. The purpose of contrasting these two approaches is to demonstrate the possibility of using the concept of governmentality to break free of the constraints of traditional theoretical frameworks with their oppositions of left and right, public and

private etc., and establish that governmentality represents a powerful, coherent, yet practical, means of exploring how the problems of providing health care are managed in contemporary liberal regimes.

Classifying health policy

In order to discuss Alford's approach to analysing health care policy making it is best to place it within some kind of context. To help us in this Osborne (1997) offers a convenient system of classification of approaches to health policy. He argues that most health policy analyses are based on a 'reactive' idea of the relationship between the concept of health and its management, expressed in policy terms. Health policy analyses tend to be reactive in that 'on the one hand, policy is viewed as a reaction to objective problems of health need and provision, and on the other, the state of health is viewed as a product of the relative effectiveness of policy' (Osborne 1997:173). He goes on to group these reactivist accounts into three broad categories:

The **'meliorist approach'**. This views health policy in terms of the gap between an objective problem of health need and the current state of medical knowledge. As medicine progresses, certain situations that are determined to be intolerable because of lack of understanding or availability of treatment, are finally overcome, and, as knowledge moves on, new ones arise to take their place. Therefore, health policy is concerned with managing this evolutionary process of dealing with 'objective problems cropping up in the social, vital or political environment' (ibid.: 174).

The **'anti-medicalist approach'**. This approach can be seen as a rejection of the notion that problems of health care have an objective basis. Health policy is seen to 'construct its concerns, and that health problems are always relative to particular societies and contexts' (ibid.: 174). Often medicine and those associated with its practice, are seen in a negative light. As Osborne observes, this approach is where Foucault's ideas are usually invoked, generally accompanied by a narrow reading of works such as *Madness and Civilisation*, *The Birth of the Clinic* or *The History of Sexuality* (see Armstrong 1997). But typically, Osborne argues 'this kind of approach

tends only to replace the dualisms of reactive accounts of health policy with a monism centred on 'power', or 'desire' or some other such concept' (ibid.).

The **'critical approach'**. In this approach it is not the objective reality of certain health related intolerables that is the central issue, but the way in which policy is 'the product of negotiations or clashes of interest between different concerned parties' (*ibid.*: 174). This is a very broad categorisation that encompasses a range of analytical perspectives from pluralism to Marxism. It includes most of the influential contemporary analyses, for example, Navarro (1978), Cawson (1982), Ham (1992), Harrison et al. (1990), Allsop (1995), Klein (1995), Mohan (1995).

Constructing Alford's structural interests model

It is in this final category that one could place Robert Alford's influential 1975 work *Health Care Politics*. This is a detailed study of the problematic state of health care in New York highlighted by numerous Commissions of Investigations that reported from 1950 to 1971. What he presents in his work is essentially a critique of policy analysis from within conventional political science. He argues that a 'narrow concept of the pluralist political process as one of winning legislative victories and an activist image of interest groups are inadequate ... to explain the persistence of health "crises" and the barriers to health care reform' (ibid.: 17). Furthermore, he suggests that reforms based on pluralist models, be they 'market' models that advocate more competition in health care, or those based on 'bureaucratic' models that argue for strategic control and regulation of health care, are all unlikely to work in the long run. This is because they fail to account for the way in which certain groups develop vested interests in the system and are able to undermine attempts at reform. Therefore, a more appropriate explanatory framework would be one in which certain interests are seen as 'structural', in that they are 'served or not served by the way they "fit" into the basic logic or principles by which the institutions of society operate' (ibid.: 14). Alford elaborates on this idea by developing a tripartite arrangement of 'dominant', 'challenging' and 'repressed' groups, each with a different set of structural interests. He argues that:

> Dominant structural interest are those served by the structure of social, economic, and political institutions as they exist at a given time. Precisely because of this, the interests involved do not continuously have to organise and act to defend their interests; other institutions do that for them. Challenging structural interests are those being created by the changing structure of society. Repressed structural interests are the opposite of dominant ones (although not necessarily always in conflict with them); the nature of the institutions guarantees that they will not be served unless extraordinary political energies are mobilised (ibid.: 14).

In terms of health care, the dominant group comprises those who share the common status of medical professional and act as 'professional monopolists', in that they exhibit a high degree of autonomy over their activities, are self-policing and control entry into the profession. It is this group whose interests are predominantly served by the current system and derive popular support from it. The challenging 'corporate rationalisers' - in the context of American health care - are a diverse group that includes hospital administrators, medical schools, government health planners, and public health agencies, all of whom share a common interest in the implementation and development of new technology or responsibility for health care organisational structures. These 'rationalisers' wish to further their own agendas by promoting a new structural arrangement in which their interests are dominant and provides a mechanism for managerial control over clinical behaviour. The third 'repressed' grouping, referred to as the 'community population', consists of a disparate collection of the poor, those just above Medicare income, families who cannot afford the high cost of medical insurance and those with chronic conditions. This group's concerns are not served by any powerful structural interests and cannot rely on institutional backing to support their cause. Moreover, although this group may score the occasional victory, because of their heterogeneous nature their demands 'are easily compromised, soothed, or co-opted into the bases of legitimation of the activities and role of dominant or challenging structural interests' (ibid.: 218).

Through this classification of 'dominant', 'challenging' and 'repressed' interests, Alford seeks to demonstrate the difficulties a pluralist model of health care would have in following the complex web of relationships and temporary alliances that exist beneath the surface of interest group politics. With regard to the medical profession,

pluralist analysis might misinterpret its heterogeneous nature and internal conflicts over territory, as a fracturing of medical interests. However, as Alford argues, because medical interests 'are at present dominant ones, with their power and resources safely embedded in law, custom, professional legitimacy, and the practices of many public and private organisations, they do not need to be as visibly active or as cohesively organised as those groups seeking change' (Alford 1975: 191). This in turn depends on a form of ownership of the dominant model of health and health care. This 'medical model', with its emphasis on professional autonomy, individualised, patient centred care, is a very familiar one which enjoys a great deal of popular support. It is this model which is reflected in the legal and organisational structures that bolster and legitimise medical power.

To counter this power, the corporate rationalisers must adopt a method that seeks to undermine medical dominance in the delivery of health care, and instead present health care problems as best met by technical or organisational solutions. The language used is one of co-ordination, integration and planning, that privileges apparently neutral concepts such as efficiency and effectiveness. However, it is clear that problems will occur when this administrative rationale starts to impinge on areas demarcated as the responsibility of medical professionals. It is in the interests of corporate rationalisers to manage the ensuing conflicts so that they 'are absorbed in a higher synthesis determined by technical criteria - themselves defined by the administrator' (ibid.: 205). But this will only be possible if rationalisers can appropriate for themselves an alternative form of legitimacy for their actions. Therefore, in effect, any challenge to dominant interest becomes a challenge to the dominant health paradigm, with the ultimate aim of placing limits on medical professional power by reducing their status to that of employee serving the new model of health.

In relation to repressed community population interests, Alford again makes the point that occasional high profile victories enjoyed by community pressure groups are no measure of the influence these groups have on health care provision. Indeed Alford argues the opposite is the case in that the 'representative' nature of many high profile planning committees relies on the disparate interests of repressed groups to obscure the decision making process. As Alford states, 'the structure of participation maximises

the chances of stalemate by setting up rules of decision-making in such a way as to prevent any major interests from seriously being damaged (the requirement of "consensus"), and by failing to allocate enough power to the decision-making bodies on which community groups are represented' (Alford 1975: 221). Such victories that do occur are then likely to be because it suits the structural interests of one on other of the dominant groups. Underlying the powerlessness of community population activists, what Alford calls 'equal-health advocates', is the inability to invoke their own institutional support to advance a model of health care that would further community interests. Real power for these equal-health advocates can only come by creating 'consciousness among the community population of the causes of the situation' (ibid.: 220).

At this point it is quite reasonable to ask of Alford what kind of health care system would meet these repressed community interests. In part Alford answers this by outlining the 'ideal' health system. He states:

> Such a system recognises the needs for both professional autonomy, on the one hand (guaranteed by strong professional organization, control over training, and high quality biomedical research), and a co-ordinated and integrated health care delivery system on the other (taking advantage of the knowledge and application of medical technology and a complex division of labor between paraprofessionals and various levels of specialized practitioners who provide both preventive and medical care). The primary care practitioner, responsible for families, is seen as the key "interface", linking the patient with a series of more specialised professional and hospital services. In the ideal system the services are presumed to be available without regard to income, through various types of subsidies, insurance programmes, and the like (ibid.: 250-1).

Why such a system has not come to pass, and why the present system in the US is in 'crisis' (as of 1975), is for Alford not because of the failure of market or bureaucratic policies but because of conflict between the major structural interests. Furthermore, these conflicts reflect the unequal distribution of power and resources within American society. To reiterate, pluralist political analysis and solutions will fail because they cannot account for underlying structural interests. Therefore, the only possibility of reform is in raising consciousness to defeat or consolidate the social power 'that has

been appropriated by various discrete groups and that preserves existing allocations of social values and resources' (ibid.: 251).

Structural interests: testing the strength of the model

In this section the Alford model of structural interests and elite power groupings will be examined two ways. There will be a discussion of the concept of power embedded in Alford's theoretical position. But, firstly, we must examine the adequacy of the Alford framework in its own terms, and how well it can be translated into a UK context.

The Alford model and the NHS

The first point that must be made about the Alford model is that it has its origin in the analysis of a specific health care system as it operated at a specific time. While most health systems have their own peculiarities, the American 'system' (if it can be called that), in many ways stands apart from those developed in other Western industrialised nations in being predominantly market based. At the time of writing in 1975, Alford describes a health care system dominated by provision within the hospital. Additionally, these, and other health care institutions, are mostly privately owned, be they for-profit or non-profit organisations. As noted earlier, Alford is also concerned with the large section of the population that has limited direct access to health care. In the years that have elapsed since his work was published it appears much of Alford's pessimism about the nature of reform has been well founded. As North (1995) points out, Alford wrote before the introduction into the US health care system of most of the technologies associated with the third party payer role adopted by private insurers or the state funded Medicare or Medicaid systems. These technologies include the creation of Health Maintenance Organisations (HMOs), that act as primary care gatekeepers, or insurance appointed case managers to oversee treatment, or approved care regimes associated with Diagnostic Related Groups (DRGs). As they are often viewed as placing restriction on the autonomy of medical professionals, they can all be easily defined as strategies associated with the interests of the corporate rationaliser. However, despite the introduction of these reform technologies, the interests of many

of the same groups described by Alford in 1975 are still not served by the US health care system. As many as 37 million of the US population in 1992 were without adequate health cover (Goldberg 1994; Buist 1992). This is despite the fact that health care costs have exploded, reaching perhaps 14% of American GDP. Moreover, even modest plans to reform the system at the federal level, such as the Clinton Plan, have foundered amidst accusations of 'socialised medicine' and denial of consumer choice (see Paton 1996). It appears that Alford's analytical framework still fits the evidence very well within an American context, in explaining how the system operates and the direction of future development. The question is whether this is a framework that fits other health care systems, in particular, the NHS?

Alford and the NHS

It is not surprising that given its success in identifying structural interests within the American health care system, that the Alford model has proved influential in a number of analyses of the British NHS system (see Allsop 1995; Harrison et al. 1990; Ham 1992). The case for the Alford model is further strengthened when the Conservative health reforms of the 1980s and 1990s are taken into account. The Griffiths report (1983), the 1989 White Paper *Working for Patients* and the NHS and Community Care Act (1990), amongst others, ushered in market inspired mechanisms that parallel the third party payer technologies outlined above. The separation of purchaser and provider function created the opportunity for a quasi-market to be developed. Purchasers were given the task of acting more strategically, appropriating a technical, neutral language that parallels that of the corporate rationaliser. However, it is equally apparent that many of the purchaser inspired strategies, such as clinical effectiveness, audit and proposals for evidence based medicine etc., are far from neutral, and can be seen as mechanisms of control aimed at limiting the autonomy of action of a powerful medical professional whose interests were served by the previous system. (The NHS reforms will be examined in greater detail in subsequent chapters). So far the model appears to fit with structure of the contemporary NHS, as it reflects a market-led health care system. However, there is a case for highlighting three key areas where the model becomes problematic. They are: the structural interests of GPs; the identification

of group interests served by the rhetoric of 'crisis'; and the degree to which repressed interests are accommodated by the NHS as a state controlled health care system.

The role of the fundholding GP

One of the practical difficulties of using the Alford model is in allocating a particular category of individuals to one or other of the structural interest groups. It is one of the strengths of the model that most of the time this is not too difficult. However, the NHS reforms present those wishing to utilise the model with a problem when dealing with GP fundholders. As North (1995) notes, in the Alfordian context, GP fundholders appear to be fulfilling two different roles simultaneously, in that they are providers of primary health care and, at the same time, act as 'informed purchasers' of care in their own right. Alford, in his model, does allow for certain groups of medical professionals to be co-opted into management. However, the function of informed purchaser does seem to imply that these GPs must themselves adopt the strategic management role of the corporate rationaliser as part of their remit as medical professions - without it having to be imposed from outside. It could be argued that the anomalous position of fundholders is a mere curiosity soon to disappear now that a new Labour government no longer advocates fundholding as the preferred option for GPs. But the problem remains that other policies that enhance the role of the GP as primary care gatekeeper are still in place. The use of locality management and GP commissioning teams, expand the purchaser role for the GP beyond fundholding. Taken to its extreme, if this enhanced purchasing role is accompanied by the devolving of budgets to locality level then it appears that more of the strategic planning role typical of the corporate rationaliser will fall to GPs as well. Given the direction of these changes and the increasing influence of GPs in the health care system it is difficult to see how this can be incorporated into the Alford model. As North (1995) states:

> In terms of Alford's typology [the creation of the purchaser/provider split] has made the categorisation of GP fundholders problematic. As purchasers, would they be more appropriately described as corporate rationalisers? Since the reforms GP fundholders have had a direct and, in some instances, robust relationship with providers... However it should not be forgotten that GP fundholders, along with non-fundholders, are providers also. Since the interface between primary

> and secondary care is considered to be an area of possible savings and competition, GP fundholders in particular are in potential competition with trust based providers (eg family planning, outpatient procedures and certain operations of a less heroic scale) North (1995: 122).

As mentioned earlier, the anomalous position the GP fundholder as a product of the Conservative reform process initiated by the 1989 White Paper *Working for Patients* may be rectified with the arrival of a Labour government in 1997. The Labour Party election manifesto committed the incoming government to act to reverse the 'two-tier' health service which Labour had identified as an unwelcome by-product of the fundholding system. However, the reform of fundholding as set out in the White Paper *The new NHS: modern, dependable* (DoH 1997) presents even greater problems for the Alford model. Although the implications of the White Paper will be discussed in the final chapter, it is relevant to mention that one of the central themes of the new reform process is to increase the involvement of GPs and other primary care workers in the commissioning process. The White Paper envisages that GPs (fundholders and non-fundholders) and community nurses would form 'primary care groups' which would ultimately evolve into 'primary care trusts' that would take over commissioning from Health Authorities. The basis of the new arrangement for commissioning health care would still continued of reflect the concepts of clinical effectiveness and evidence based medicine that were part of the Health Authority remit. Again we see the distinction between the professional monopolist and the corporate rationaliser being blurred. A distinction which can only be accommodated in the Alford model by fracturing the central concept of structural interests associated with particular groupings. However, it is the identification of a well-defined set of structural interests that gives the model its internal cohesion and explanatory power. To weaken this structure is to weaken the model.

The rhetoric of Crisis

A different concern with the Alford framework is in the method of identifying challenging interests. Almost by definition challenging groups have to disrupt the present system that serves the needs of dominant interests, and make their interests paramount. Alford makes it quite clear that the rhetoric of 'crisis' in the US health

system, assists challenging corporate rationaliser by discomforting dominant professional monopolists and destabilising their entrenched power. As Alford states:

> It is significant that most definitions and diagnoses of health 'crisis' do not come from professionals. The AMA [American Medical Association] and other professional associations have largely reacted defensively, proposing alternatives and compromises only when other interest groups have raised challenges to existing practice. When institutions and laws continuously serve dominant structural interests, challenge must come from elsewhere (Alford 1975: 209-210).

For Alford, 'crisis' has to been seen as the by-product of the struggle between competing interests. This is not to say that the language of 'crisis' does stem from real inadequacies in the health system, but Alford points out that the language of 'crisis' is instigated by the official Commissions of Investigation, whose composition is dominated by individuals associated with the interests of the corporate rationaliser. However, in a UK context, the link between 'crisis' in the NHS and the interests of corporate rationaliser is more difficult to sustain. It is one of the innate characteristics of the NHS that while medical professional are theoretically free make any decisions they feel is necessary to meet the health need of their patients, they do so against the background of finite budgets. However, one of the dynamics of health care is that new areas of need are continuously created as more and more new treatments and new technologies are developed. Therefore, the continuous expansion of need coupled with limited resources result is 'an irresistible force constantly clash[ing] with an immovable object, leading to periodic political 'crises' on the funding issue' (Ranade 1997: 2). In effect, dealing with recurrent 'crisis' becomes part of the political governance of the NHS. The Alford model is less helpful in this respect because the rhetoric of crisis can be associated with the concerns of those identified with corporate rationalisers interests *and* those identified with professional monopolists interests. For example, the difficulties in maintaining or containing health spending against a background of economic downturn or attempts to control government spending, will increase political interest in management initiatives that generate increased efficiency within the NHS (see Klein 1995). Effectively, the identification of 'crisis' in other spheres of government activity, such as the economy, forms the pretext to extend managerial control over health spending. To some extent, this is how one could view the Griffiths

Report and *Working for Patients* and other aspects of the NHS reform process in the 1980s and 1990s. However, at the same time, the rhetoric of 'crisis' is deployed by medical professionals to campaign against perceived cuts or shortfalls in funding (see Ham 1992). The British Medical Association (BMA), as well as individual clinicians, have, at times, been vociferous in their opposition reforms in the health service, warning of the dire consequences to patient care that may result.

Therefore, one of the main difference between the British and US use of 'crisis' language is in the identification of the origin of the contemporary difficulties. In the US it is the system itself which is in crisis, in the UK the crisis stems from difficulties in maintaining adequate funding for the NHS, emphasising failure of financial management rather than failure on the part of medical professionals. The obvious explanation as to why the rhetoric of 'crisis' in the UK belongs to professional monopolists as well as corporate rationalisers, reflects the fact that the NHS is an almost entirely state-funded and state-owned health care system. Corporate rationalisers, if they can be said to exist within such a system, would necessarily be agents of the state and ultimately responsible for administering the system. Therefore, talk of 'crisis' within the NHS can be read as failure on the part of health service managers, and by extension, the government itself to control the health care system. Hence, the calls by government for management reform. On the other hand, agitation for more funding because of the inadequacies revealed by the medical professions can be seen as reflecting the secure position enjoyed by the profession. Professionals will not point out problems in a system in which they are implicated if they think they are going to be blamed for its shortcomings.

The NHS and repressed interests

Thus it appears that the Alford model starts to become problematical when used as a framework to explain state controlled health services. This is reinforced by the next issue - how are repressed interests reflected in the structure of the NHS as a health care system? As noted earlier, for Alford, repressed interests are repressed because they have no real institutional support, but ultimately, the reason for this situation is the lack of consciousness about the causes of their problems. In the power-play

between powerful structural interests, real need is not met. It is the crux of Alford's argument that any reform process designed to consistently meet real need will only perpetuate health inequalities if underlying structural interests are not taken into account. In essence, competition between structural interests creates a false consciousness that prevents 'real' interests being met. This is a powerful and compelling analysis of the how health systems work, especially in the American context. Within the NHS it has been noted that community input into the decision making process has been very limited. One of the consequences of recent reforms of District Health Authorities is their divestment of local authority representation, and, reflecting their new streamlined managerial agency status, their replacement with non-executives recruited predominantly from the local business community. However, health authorities have been given the responsibility of purchasing the most appropriate health care for the local population, the logic of which demands some profound changes in health service thinking. If health care is to be purchased for the local population, the health authority must have some notion of what those health needs are and identify the most efficient methods of meeting those needs. To do this it must systematically engage with the local population as enjoined to do so by the government through such initiatives as *Local Voices*, and in effect to become the 'champion of the people' (NHSME, 1992). In the context of the Alford framework it is clear that community population interests cannot be fully represented within management controlled structures. Even statutory bodies outside these structures such as Community Health Councils can only have a limited impact. CHCs are charged with independent representation of consumer interests yet from their inception, have been hampered by low levels of funding, limited powers in shaping service provision beyond their statutory right to be informed of service changes, and weak powers of inspection of providers (Allsop 1995; Lupton et al. 1995; also see Chapter 8). As North points out:

> Despite the fact that the NHS is owned, financed, and managed by the state, however, the community does not have the means to express a view on how much is spent on local health care, or the performance of the Health Authority or commission. The ballot box is a crude way of registering voter dissatisfaction with the national health service, let alone its local manifestation. For the present, the articulation of community interests is channelled through consultation exercises which,

> though probably well-meaning, is subordinated to the corporate rationalisers' perception of what is appropriate (North 1995: 124).

However, despite the above, what Alford was at pains to point out was that one must look beyond the pluralistic concept of competing voices to the deeper structures that deny the community population its 'real' interests. A strong argument is made that these interests can be met by an 'ideal' health care system of the kind outlined earlier (Alford 1975: 251). This 'ideal' system is comprehensive, does not depend on income, it has a gatekeeper role for primary care practitioners, it guarantees a fair degree of clinical autonomy, and most of all, there is strategic management to make best use of resources. In the UK context this all seems very familiar. Put on a pair of very rose-coloured spectacles and what you see is the model of health care to which the NHS aspires. Does this mean that the NHS meets repressed community population interests? It would take a vary brave person to say yes. But given that, it does have more than a passing resemblance to the 'ideal' model that competing structural interests deny repressed interests. So how does this fit with the Alford model? While it does not undermine the model it does pose some difficult problems that have to be addressed. The Alford model works well at identifying powerful structural interests and it is not difficult to assign different groups within the NHS structure to different competing interests. But what is more difficult is it in identifying what form the NHS would have to take to meet real needs once powerful structural interests are countered. Or do we view the NHS as part of the problem rather that as a source of a solution? Is the NHS a reification of structural inequality, which must be replaced entirely if repressed community population needs are to met? At the heart of this problem is the concept of uncovering and understanding exactly what constitute unconscious, 'real' interests. This will be explored in the next section.

Analysing power

As noted earlier, the Alford model of policy making has at its heart the rejection of pluralist politics. In essence, it is an attempt to move beyond the conception of power associated with Robert Dahl (1957) and his classic study of local politics *Who Governs?* In this formulation of power, 'A has power over B to the extent that he [sic]

can get B to do something that B would not otherwise do' (Dahl 1957: 80). In order to study these power relations in action one has to 'determine for each decision which participants had initiated alternatives that were finally adopted, had vetoed alternatives initiated by others, or had proposed alternatives that were turned down. These actions are then tabulated as individual 'successes' or 'defeats'. The participant with the greatest proportion of successes out of a total number of successes, were then considered to be most influential' (ibid.: 336). For Alford this emphasis on the observable, 'concrete', decision making process is clearly insufficient. He seeks to go beyond it by incorporating other dimensions of power into his analysis. Although Alford does not refer to him specifically, his working hypothesis of power has much in common with that of Steven Lukes (1974). Lukes emphasises the importance of the third-dimension of power, transcending the analysis of actual conflict, be it associated with decision making (Dahl) or control of what reaches the agenda for discussion, the non-decision making process outlined in the work of Bachrach and Baratz (1970). As in Alford's concept of repressed interests, Lukes (1974) argues that there are:

> many ways in which *potential issues* are kept out of politics, whether through the operation of social forces and institutional practices or through individuals' decisions. This, moreover, can occur in the absence of actual, observable conflict, which may have been successfully averted - though there remains here an implicit reference to potential conflict. This potential, however, may never in fact be actualised. What one may have here is a *latent conflict*, which consists in a contradiction between the interests of those exercising power and the *real interests* of those they exclude (Lukes 1974: 25; author's emphasis).

This appears to be saying that A may still be exercising power over B, because B's real interests are not what B believes them to be (or for that matter what A believes them to be). This false consciousness on the part of B is a result of an ideological construction of consciousness that present the interests of A as natural and unalterable. In terms of Alford's analysis, ideologies associated with powerful structural interests blind repressed interests from their real needs so as to pose no threat to the position of those powerful interests. This form of analysis has traditionally been shared by many other approaches to the concept of power and policy making. It is evident in Marxian analysis, and other variations such Critical Theory developed by the Frankfurt School.

However, implicit within this theorising is that false consciousness and critical engagement with ideology imply that it is possible to have *true* consciousness, thinking *free* of ideology, and that 'ideology is the result of distortion introduced by the oppressive exercise of power by the dominant class. Only if such distortions were seen through and repression dispelled would true consciousness be possible' (Hoy 1986: 131).

The concept of power and ideology outlined above is quite clearly at odds with Foucault's notion of power/knowledge. As described in the previous chapter, for Foucault power and knowledge are different aspects of the same concept. In this formulation, knowledge is not independent of power or exists outside discourse as some kind of reflection of external truth. Foucault is not alone in implicating knowledge with power. For example, Habermas (1972) also has the notion of knowledge always being linked to interests. But the crucial difference for Habermas is that he proposes a form of self-reflexive knowledge acquisition that has an 'emancipatory interest in achieving rational autonomy of action freed from domination' (Blaikie 1993: 54: also see Hoy 1986: 132). Foucault does not hold out such a prospect. As he states, 'it's not a matter of emancipating truth from every system of power (which would be a chimera, for truth is already power), but of detaching the power of truth from the forms of hegemony, social, economic, and cultural, within which it operated at the current time' (Foucault 1984: 74-75). The previous chapter outlined the way in which this can lead to a pessimistic reading of Foucault. Escape from one discourse only results in being implicated in another one. There seems no hope of any kind of freedom. However, it is possible to argue that Foucault provides a different form of freedom, an escape from traditional ways of thinking and looking at how policy is created. This is only possible by looking at power differently, within the concept of power/knowledge, and seeing that it is not always negative. As Foucault states:

> What makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network

> which run through the whole social body, much more than as a negative instance whose function is repression (Foucault 1984: 61).

This is quite a different concept of power than, for example, the one used by Alford. In the Alford model the focus of analysis is on conflict and repression. It forces one to think of certain groups as acting in a predominantly negative way. Moreover, the analysis forces individuals to be compartmentalised with others who are deemed to have the same structural interests. The model incorporated a number of oppositions: the powerful and the powerless; ideology and freedom; perceived interests and 'real' interests. It is one of the strengths of Foucault's ideas that it is possible to avoid such oppositions. This is especially true of governmentality and in particular the study of liberal form of governmentality. As Rose and Miller argue:

> [T]he political vocabulary structured by oppositions between state and civil society, public and private, government and market, coercion and consent, sovereignty and authority and the like, does not adequately characterise the diverse ways in which rule is exercised in advanced liberal democracies... Power is not so much a matter of imposing constraints upon citizens as of 'making up' citizens capable of bearing a kind of regulated freedom. Personal autonomy is not the antithesis of power, but a key term in its exercise, the more so because most individuals are not merely the subjects of power but play a part in its operation (Rose and Miller 1992: 174).

The latter part of this quotation cannot be emphasised too greatly. For Foucault, power and freedom are not opposites. Liberal forms of governmentality are predicated on the notion of the autonomous, reflexive and recalcitrant individuals capable of resisting power. Where there is power there will always be resistance in the form of a 'permanent provocation' between power and the individual, which Foucault describes as 'agonism'. But what is also important to note is that just as power somehow 'makes up' the individual, power itself has no essence beyond the discursive boundaries described by governmentality. This has practical implications in the use of governmentality in analysing contemporary policy formation.

The first implication is that if power has no reality until it is exercised at the micro-level, the object of a governmentality-type framework is to map out these

manifestations of micro-power in order to say something meaningful about the way in which the discursive space of government is regulated. However as Hoy notes, 'if power is to be taken nominalistically - not as a real substance or as a property, but simply as a name for a complex strategy or grid of intelligibility - then, admittedly this grid could be mapped in different ways, and there is no final, privileged, or foundational mapping (Hoy 1986: 138-140). The consequence of Foucault's 'pragmatic nominalism', as Hoy calls it, is that this analytical mapping of micro-power is only valid as long as it is useful. This implied agnosticism is critically different from the *a priori* assumptions of *real* power and *real* interests that form the basis of much traditional ways of analysing policy, including Alford. Additionally, when agents do exercise power they do so *through* the authority given to them by their positions within the mechanisms of security as part of the power/knowledge discourse. Power is not some tangible entity in the possession of certain individuals, groups or intuitions. As Rose and Miller, citing Latour (1987), state, 'a powerful actor, agent or institution is one that, in the particular circumstances obtaining at a given moment, is able to successfully enrol and mobilise persons, procedures and artefacts in pursuit of its goals' (Rose and Miller 1992: 183). Therefore, it must be central aim of a governmentality analysis to identify those structures and technologies (past and present), which validate and legitimise the actions of those actors, agents or institutions. It must also develop an understanding about why, in the field of all the possible actions, one action occurs rather than another. The next section will look at one such mechanism, argued to be central to the regulation of liberal formulas of government: the role of expertise.

Expertise, liberalism and neo-liberalism

In the section above, it was argued that within a governmentality paradigm, power can only be said to be real in that it produces real effects. Beyond these real effects power is only an abstraction that allows practical investigation as to why the actions of some individuals are realised and others prevented, or circumscribed. The value of governmentality is that it offers a way of linking the real effects of power at the micro-level to the macro and meso analysis of governance as a problematisation of rule, in a way that renders it 'thinkable' (Rose and Miller 1992). This problematised space is

then analysed in terms of those technologies of government that make up the 'complex of mundane programmes, calculations, techniques, apparatuses, documents and procedures through which authorities seek to embody and give effect to governmental ambitions' (Rose and Miller 1992: 175). In liberal forms of governmentality these ambitions are directed at the concept of the well-being of the population as the source of the strength of the state (see Chapter 2; Gordon 1991; Burchell 1991). However, the reflexive nature of liberalism as a mentality of government, continuously leads to the questioning of the boundaries between the political/public domain of government activity and the non-political/private domain, the preserve of the autonomous individual. The heart of the liberal formula of government is setting these boundaries appropriately. The problem for all types of liberalism is that most of the regulation of the population takes place in the non-political/private domain, particularly within the structure of the family. It is in this context, it is suggested, that the concept of expertise has evolved in the last two centuries as a technology of control and surveillance so that liberal governments, having identified this private domain outside politics, 'seeks to manage it without destroying its existence and its autonomy' (Rose and Miller 1992: 180).

One of the key concepts in the regulatory politics of population is Foucault's notion of 'bio-power'. This includes the mass of techniques that focus on the body as 'imbued with the mechanics of life and serving as the basis of the biological processes: propagation, birth and mortality, the level of health, life expectancy and longevity, with all the conditions that cause these to vary' (Foucault 1981; in Rabinow 1984: 262). The collection of data involved in this 'will to knowledge' about the activities of people, seems to transform the population into a centre of calculation, thereby rendering it somehow real and amenable to analysis (see Latour 1987). The language of calculation is statistics, but it is used in such a way as to render it a neutral language that generates and codifies 'normality' and highlights deviance. Statistics is presented almost as a 'moral science' (Hacking 1991). The high priests of this calculation and regulatory technology are defined as specialists in a form of expertise. The hope is that in applying the knowledge of experts, 'that problems of regulation can remove themselves from the disputed terrain of politics and relocate onto the tranquil yet seductive territory of truth' (Rose and Miller 1992: 188). The steady accretion of

knowledge about populations and expertise leads to a re-categorisation of individuals and the emergence of certain behaviours and sources of disorder, such as criminality, promiscuity or outbreaks of disease, being re-codified as 'social problems' and subject to regulatory control (see Foucault 1980; Rose 1993). In effect, liberal forms of governmentality seek to regulate the private domain 'at a distance' by harnessing 'forms of authority other that those of 'the State' in order to govern' (Rose 1993: 292). These forms of authority are essentially provided by experts and expertise.

Expertise and health policy

This notion of governing 'at a distance', is particularly important when dealing with health and health policy. As Osborne (1997) points out, health is negative concept, 'lived in the silence of the organs', quoting Canguilhem (1989). Health is thought of in terms of an absence of something, such as disease or infirmity. As such it is 'simply impossible to institute a determinate 'right' to health' (ibid.: 179). Therefore, health policy must necessarily be indirect. The role of expertise, in this case professional medical expertise, takes on greater importance as regulator of a healthy population - and the ultimate source of the strength of the state. But as Osborne goes on to argue:

> A liberal capacity to govern will tend to stress the provision of infrastructural conditions of health living - sewage systems, clean water supply, a state-regulated but not state-controlled medical profession - but at the expense, in the main, of direct injunctions to lead a healthy lifestyle, to transform oneself in the interests of one's own health and longevity (Osborne 1997: 182).

However, there is clearly a danger for liberal forms of governmentality in allowing medical professions, and experts in general, too much autonomy. As Rose and Miller (1992) suggest, there is a possibility that devolved control combined with the exclusive technical knowledge of expertise will lead to 'enclosures', a form of reification of the networks of regulatory authority, that can be defended and built upon. By way of an illustration, they argue that the traditional authority of clinicians within the NHS made 'their arguments and calculations the obligatory mode for the operation of the network as a whole, the lines of force flowing, as it were, from the operating theatre to the

cabinet office and not vice versa' (Rose and Miller 1992: 188). Moreover, following on from this, it can be argued that the institutionalisation of medical expertise also institutionalises the notion of health care as being essentially curative in nature and focused on the individual - in effect, the creation of the 'medical model' of health care discussed earlier in relation to the work of Alford. Additionally, the emphasis on curative health care leads to health, as a concept, being seen in terms of the manifestation of illness and disease that is ameliorated by the ministrations of the medical profession. As Osborne has already observed this can result in a lack of personal responsibility in preventing illness. And, in certain circumstances, where there is a collective approach to health provision, this also leads to a degree of passivity by the patient and an unwillingness to confront authority.

As the layers of expertise-based regulation have steadily built up since the nineteenth century, the reflexive dynamic within liberalism has started to reassert itself. The dynamic principle of liberalism is founded on 'the fear of not governing enough versus the fear of governing too much' (Rose 1993: 292). It could be argued that the growth of welfarism, and with it the creation of such institutions as the NHS, are the product of expert-based technologies of government. The questions is whether these government sponsored invasions of the private domain can be represented as a form of 'arrogance of government overreach and overload' (Rose and Miller 1992: 198). The rise of neo-liberalism can be seen as an affirmative answer to this question. The result is a re-problematisation of the governed space, that sees welfarism as the product of an overextended government mentality that places too many limits on the interests of the self-reliant, self-disciplining individual of classical liberalism. As Rose and Miller state:

> Neo-liberalism re-codes the locus of the state in the discourse of politics. The state must be strong to defend the interests of the nation in the international sphere, and must ensure order by providing a legal framework for social and economic life. But within this framework autonomous actors - commercial concerns, families, individuals - are free to go about their business, making their own decisions and controlling their own destinies (Rose and Miller 1992: 199).

Within neo-liberalism, welfarism is re-coded as a threat to the functioning of the state by virtue of the burden it places on the economy and in the malign way it which it

creates a culture of dependency and passivity. The principal dynamic of neo-liberalism is to be found in the concept of 'the market'. This leads to the assertion that free market economics is 'capable in principle of addressing the totality of human behaviour, and, consequently, of envisaging a coherent, purely economic method of programming the totality of governmental action' (Gordon 1991: 43). Taken to the extreme, this notion of *homo economicus* can be seen in the work of Gary Becker *(1976) and the 'new institutional economics'* of Oliver Williamson (1975), extending economic models into previously non-economic subject areas (see Chapter 5).

The Conservative governments of the 1980s and 1990s are a prime example of this re-problematisation in action. These administrations instigated a radical programme of reform in part guided by the central tenets of the free market. The privatisation of nationalised industries and utilities, competitive tendering for services and deregulation, can all be seen as part of a reformulation of liberalism in terms of minimal government and 'rolling back the state'. For those sector of governmental responsibility, such as the NHS, that were deemed as unsuitable for exposure to the full rigours of the free market, reforms attempted to mimic the mechanisms of the market. Thus, the purchaser/provider split and the introduction of the internal market, were to provide the basis of a managed, quasi-market in health care. These were accompanied by the creation of a new set of targets to be met - for waiting lists, return on capital etc. - as well as the measurement of activity - numbers of patients treated, or Finished Consultant Episodes (FCEs). As Osborne (1997) argues, these are consistent with neo-liberal technologies' production of 'surrogate' variables 'that will stand measure for otherwise abstract ideas of health... Neo-liberalism abandons the quest for an absolute that would be 'health' and opts for determinant strategies, targets and specifics instead' (Osborne 1997: 185). But this represents more than just the reorganisation of the management; neo-liberal health policy incorporates a new paradigm for health care. Neo-liberalism is predicated on individuals taking responsibility for their own health and not relying passively on the state. This manifests *itself in the emergence of ideas surrounding the concept of a 'new regime of total* health care' and a re-emphasis on public health (see Armstrong 1993; Nettleton 1995). One approach is the so called 'New Public Health', with its emphasis on health promotion and lifestyles. Here there is recognition that, 'many contemporary health

problems are therefore seen as being social rather that solely individual problems; underlying them are concrete issues of local and national public policy, and what are needed to address these problems are 'Healthy Public Policies' - policies in many fields that support the promotion of health (Ashton and Seymour 1988: 21). This re-coding of health problems as social problems is indicative of neo-liberal health policy, where, in contrast with the collective social risk of welfare liberalism, it is incumbent on the individual to engage in a form of self-entrepreneurialism of health, to avoid risky behaviour so as not to place a burden on the rest of society. In reality, individualisation of risk becomes the new paradigm of governance, a more stringent form of self-governance.

The risk society

The concept of risk in modern western societies is not exclusive to Foucauldian forms of analysis. For example, two dominant figures associated with the concept of risk in late modernity are Ulrich Beck (1992, 1994) and Anthony Giddens (1990, 1991,1994). They advance the concept of reflexive modernity as 'a third way' between modernism and postmodernism (Beck, 1994: 174). Although there are differences in the emphasis each places on the consequence for change in particular areas of society, both agree that the management of an all-pervasive risk is the key to understanding the transformation of modernity. As the certainties of modern society break down in the post Cold War world, risk becomes individualised. Thus for Beck (1994):

> In the risk society, the recognition of the unpredictability of the threats provoked by techno-industrial development necessitate self-reflection on the foundation of social cohesion and the examination of the prevailing convention and foundations of 'rationality'. In the self-concept of risk society, society becomes reflexive... which is to say it becomes a theme and a problem for itself (ibid.: 8).

The risk society comes about through a process of reflexive modernisation, in that as society modernises 'the more agents (subjects) acquire the ability to reflect on the social conditions of their existence and to change them in that way' (ibid.: 174). The key to this transformation is 'individualisation' in which the now reflexive individual

becomes aware of the latent dangers of the industrial society which can no longer be hidden, and therefore, is compelled to become dis-embedded from the conventions and norms of the industrial society and be re-embedded in the new risk society with all its contingencies (see Giddens 1991). The consequence of this is that choice has expanded. The individual can create a 'reflexive biography' for themselves through their own actions. However, the problem with this is that former networks of trust in others or institutions of the state become weaker and the individual's ontological security becomes diminished. The individual must then attempt to devise new strategies of creating certainties. New networks of trust are established and more trust is placed in the expert or in science. But above all, some sense of security is generated by the reflexive management of personal risk.

Clearly this formulation of society based on the management of personal risk has much in common with the ideas associated with a governmentality type analysis outlined earlier. There is a shared language of reflexivity, expertise and construction of self in terms of risk. However, it can be argued that Foucauldian concerns with regulation of population and individuals through expertise and risk management, place these concerns within a wider, more coherent theoretical framework (see Petersen 1997). Liberal forms of governmentality, in creating a problematised space in which governance can be made 'thinkable', already incorporates an idea of reflexivity. As Rose (1993) points out:

> Analyses of governmentality do indeed concern themselves with a certain 'reflexivity' that appears to characterise the problematics of rule in our present. This is not indicative of some terminal stage of modernity; on the contrary, it is a type of analysis that emerges in nineteenth-century liberal political rationalities. Liberalism confronts *itself* with the question of 'why rule?' - a question that leads to the demand that a consistent critical scrutiny be exercised over the activities of those who rule - by others and by authorities themselves (Rose 1993: 292).

The risky individual

It can really be no surprise that the concept of individual risk has emerged has a dominant element in neo-liberal social policy. Taking a global view, the welfare state as a collective form of insurance, is essentially a technology of risk. Effectively, the technology of insurance, like governmentality, forms a bounded rationality in which control can be exercised over what otherwise is an undifferentiated mass of infinite possibility. As Ewald (1991) states, 'as a technology of risk, insurance is first and foremost a schema of rationality, a way of breaking down, rearranging, ordering certain elements of reality' (Ewald 1991: 199). Therefore, it would not be too bold to assert that insurance as an institutionalisation of risk itself represents a form of governmentality. Returning to the specifics of health policy and the NHS, the reforms of the 1980s and 1990s created market structures that echo those of private health insurers, but with two important differences. The NHS continues as a system that contains both purchaser and provider functions and the 'bottom line' of government investment in health is not financial return but improvement in the health of the population.

In the old form of welfarism and health care as social insurance, risk was collectivised and unconscious. If anything risk was equated with danger, related to potential threat from outside the collective, from the 'abnormal' individual. However, with the neo-liberal re-emphasis on personal responsibility, collectivisation gives way to the privatisation and individualisation of risk and the duty of citizens to act prudently (see O'Malley 1992). The privatisation of risk is then associated with a shift away from curative medicine towards health promotion, such as the new public health agenda, and related policies such as the 'Health of the Nation' and 'Healthy Cities' initiatives. However, the main difference is the subtle re-construction of the subject of the discourse of risk. As Castel (1991) suggests:

> What the new preventative policies primary address is no longer individuals but factors, statistical correlations of heterogeneous elements. They deconstruct the concrete subject of intervention, and reconstruct a combination of factors liable to produce risk. Their primary aim is not to confront a dangerous situation, but to anticipate

> all the possible forms of irruption of danger. 'Prevention' in effect promotes suspicion to the dignified scientific rank of a calculus of probabilities (Castel 1991: 288)

What marks this as different from dangerousness is that we are all subject to this calculus of risk. Age, gender, weight, height etc. are all inescapable factors that denote some form of risk to some ailment or infirmity. There are factors based on behaviour - what you eat (or do not eat), how much you drink, how much exercise and so on. Ultimately, every aspect of modern living can be viewed in terms of risk. Every activity is suffused with risk. Even passivity is not risk free. The air we breathe, the food we eat, the water we drink. Elements of everyday life that where once the sources of certainty have become threats to our well-being. In that sense, life has become filled with risk from which we cannot escape.

Conclusion

In this chapter, it was argued that governmentality analysis produces a distinctive way of conceptualising power relations involved in the policy making process. As such, governmentality provides an alternative analysis that provides an implicit critique of many contemporary analyses of policy formation. The influential work of Robert Alford (1975) and his use of the concept of 'structural interest' as a factor in the production of health policy was critically assessed on two counts: its usefulness as a model of health policy in the context of the NHS; and Alford's concept of power linked to structural interests. The critique of Alford's position comes from Foucault's radical re-working of the concept of power and his concept of power/knowledge discourse as the framework in which certain technologies of government develop which legitimise groups and individuals in their use of power over others.

This chapter, together with preceding chapter, has made a case for Foucault's concept of governmentality as a practical methodology for investigating contemporary health policy. It provides a useful framework to analyse recent changes in the NHS, particularly as they relate to the rise of neo-liberalism as a new problematisation of liberal governmentality. Neo-liberalism re-asserts the centrality of the autonomous

individual and represents a direct assault on collective social welfarism. The emphasis on the market and competition as the dominant model within the political economy redefines the role played by expertise in the technology of government. Moreover, the fracturing of socialised forms of welfare enjoins the individual to adopt a type of entrepreneurialism of the self, in effect to actively seek to manage personal risk that was once secured as part of collective provision. In essence, the governance of health care becomes the management of individuals defined in terms of the calculation of risk factors. This can be seen in the strategies associated with the so-called 'New Public Health'. The next two chapters will discuss the implications this new emphasis on risk has for the role of expertise and management of priorities within the NHS.

Chapter 4

Liberalism, professional expertise and clinical autonomy

Introduction

In the previous chapter it was argued that the role of expertise has become a key technology of regulation in liberal formulas of governance. Liberal mentalities of governance clearly differentiate between those domains that fall within the remit of appropriate political activity and are, therefore, the responsibility of the government and those domains inhabited by the autonomous, self-regulating individual. Within what could be termed welfare liberalism, expertise is important in allowing the regulation of those parts of society ostensibly in the private domain - such as the institution of the family - which fall outside the formal control of the state. It is argued that in this discourse of rule, expertise has evolved as a means of applying a 'neutral', scientific body of knowledge that enables the state to control this private domain 'at a distance' (Osborne 1997). However, it is significant to note that despite the functional importance of expertise to liberalism, this does not imply that every formula of liberalism necessarily incorporates the role of expertise in the same way or that expertise is employed by the state as a *conscious* strategy of control and regulation. Instead it must be seen as part of a particular articulation that makes governance meaningful and amenable to political calculation as a tangible reality.

The articulation of liberalism as a mentality of governance is founded on a simple but important dynamic - safeguarding the rights of the individual yet, at the same time, guaranteeing the 'strength of the state' which is dependent on the well-being of the population. Moreover, this dynamic leads to a form of reflexivity, a continuous questioning of the boundaries of appropriate political activity. Consequently, as part of this dynamic, it follows that the appropriate role of expertise is also likely to be questioned. Therefore, if governmentality analysis provides a framework in which to describe the changing nature of the articulation of governance within liberalism, then expertise must necessarily be viewed in the same way - as historically contingent and constructed through discourse. Thus any claims of 'neutrality' or extra-discursiveness

for the body of knowledge embedded in expert practice is inevitably subject to questioning.

However, what is not clear within the analytical framework of governmentality, is why certain bodies of knowledge attain their status as forms of expertise and why others do not. Similarly, it is not evident why some occupations become professions and why others are denied this status. These questions become particularly acute when discussing the role of medical professionals and the provision of health care within neo-liberal formulas of governmentality. In recent times, Britain has experienced a re-awakening of free-market ideology. The consequence of this has been a series of reforms that have supposedly exposed the NHS to the rigours and rhetoric of competition in the hope of providing 'value for money' and a more efficient and effective health service. However, any re-articulation of a liberal form of governance must have consequences for pre-existing forms of expertise associated with the previous articulation of governance. As Osborne (1993) states:

> As patients are urged to act like consumers, and doctors like entrepreneurs, it appears that imperatives generally associated with the pursuit of profit have replaced the prerogative of clinical truth in the organisation of medical life. This apparent denigration of clinical expertise in defining the priorities of the health field has had perceived consequences in relation to professional values. Neo-liberalism is said to have been corrosive of the professions, as doctors and other health professionals strive to maintain their autonomy against the encroachments of administrators and economists (Osborne 1993: 345-346).

One problem with governmentality analysis is that it is ambivalent about the nature of the transformations of expertise. The historical contingencies that influence the development of expertise mean that the particular political, social and economic contexts in which expertise is situated take on greater empirical significance. Governmentality as an analytical framework impels the researcher to uncover these contingencies in which expertise is implicated. However, this concern with contemporary challenges to professional power is not unique to governmentality. Over the last thirty years a large body of scholarly literature on the subject of professions has developed. This literature, which also examines the perceived crisis in professional

authority, can also provide an opportunity to examine the mechanism by which professions are created and sustained. It may answer some of the questions posed earlier about the evolution of professional expertise, especially that associated with the medical profession. Therefore, a critical engagement with this professions literature provides a means of understanding the particular circumstance in which professions are formed, and will make possible a more nuanced approach to governmentality. As noted earlier, governmentality as a form of theoretical analytical framework, in itself, provides no ready way of mapping particular forms of liberalism to particular forms of expertise. Thus the inclusion of a discussion of the historical contingencies exposed by the professions literature increases the explanatory power of governmentality as a practical methodology.

In the light of these arguments the rest of this chapter is divided into two parts. The first part reviews the literature concerning professions, emphasising the compatibility of the analytic frameworks employed in the discussion of professions with that of a governmentality framework. The second part of the chapter discusses how changes in the nature of professional medical expertise reflect changes in the discourse of governance, and the effect this has on the traditional relationships medical professionals have with patients, other medical professional and health care managers.

Professionalism and expertise

It is generally accepted that the world of medicine provides perhaps the archetypal examples of a 'professional' occupation within the academic literature on professions (Freidson 1970). Additionally, medicine and medical professionals are quintessential examples of bodies of technical knowledge considered to exhibit the characteristics of expertise so important to governmentality forms of analysis (Rose 1993; Osborne 1997; Johnson 1995). Quite clearly the notion of professionalism and expertise share a 'common sense' definition, in that professionals and experts are both thought of as bodies of individuals, which through dedicated and lengthy training, are able to make use of valuable, but esoteric, forms of expertise for the benefit of society. But what is not clear is whether the academic analytical frameworks in which these two concepts

are implicated, demonstrate a degree of mutual compatibility so that a coherent synthesis can emerge that provides useful insights for both frameworks.

Although expertise is defined more in terms of function rather than any essential nature it is thought to possess, it is clearly more that just an epiphenomenon of liberal forms of governmentality - one of the range of functional technologies of regulation that evolve within particular formulas of rule. Furthermore, expertise is not trapped within a rigid type of functionalism that precludes the development of other structures not directly connected with the functional imperative. As noted in Chapter 3, Rose and Miller (1992) suggest that experts can use the exclusive technical knowledge they administer to produce a process of 'enclosure', and thus develop organisational structures which can be defended and from which interests can be furthered. Such 'enclosures' are interpretable as forming the basis of 'profession' organisations. As Johnson (1995) suggests:

> From a Foucauldian perspective, a history of the professions becomes one part of the transformation of power associated with governmentality, as 'the disposition of things'. The rapid crystallisation of expertise and the establishment of professional associations in the nineteenth century was directly linked to the problems of governmentality - including the classification and surveillance of populations, the normalisation of the citizen-subject and the discipline of the aberrant subject (Johnson 1995: 11).

In this context it is possible to outline some of the characteristics of professions as they relate to the function of regulating the private/non-political domain within governmentality analysis. The first characteristic is that these 'professions' are seen to have ownership, and therefore control, over a technical/scientific body of knowledge. Secondly, they are able to develop the body of knowledge so as to produce new categories of individual amenable to regulatory control. Thirdly, because of the functional importance of distancing the state from the overt regulation of the private domain, they must be seen to enjoy a large degree of autonomy of action as to how expert knowledge is employed. As a consequence of this autonomy, the profession has to protect its 'enclosure', by self-regulation of its members and control of entry into the profession. However, it must be re-emphasised that all these characteristics are

contingent on the definition of expertise as a functionally important form of regulation. If the articulation of governance changes, so will expertise. The result is that, in extreme cases, some forms of expertise will no longer be considered as expertise. In effect, they will have superseded and replaced by other occupations which utilise different forms of regulatory expertise more relevant to the new articulation of governance. Therefore, occupations once deemed to be professions would lose their status. The question that now arises is how does the above definition of professionalism correlate with the working definitions employed by those who analyse the concept of professionalism outside governmentality analysis? And if they do share something in common, to what extent can they be incorporated into a governmentality discourse?

Professionalism and autonomy

The immediate problem when discussing the professions literature is that each author utilises a slightly different definition of what make an occupation a profession. This is not surprising as it appears that medical professionals have great difficulty in defining the concept themselves (see Harrison et al. 1984). This point is reinforced by Eliot Freidson, one of the seminal writers on the subject of professions. As he argues, 'no small part of the criticism of the traditional literature on professions has been devoted to pointing out a lack of consensus. Because... usage varies substantively, logically, and conceptually' (Freidson 1994: 15). Freidson himself identifies two basic elements of professionalism, 'commitment to practising a body of knowledge and skill of special value and to maintaining a fiduciary relationship with clients' (ibid.: 200). In order to attain this knowledge, a long period of training is necessary, to the point where it becomes a source of intellectual stimulation and a 'central life interest', rather than just an occupation. The important fiduciary element also stems from the application of highly technical, esoteric knowledge. The client has to take on trust that the professional is acting in the client's best interests. Without an assumption of trust there can be no relationship between practitioner and client, and the concept of the profession implodes. Therefore, what marks professions from other occupations is the degree of autonomy granted to practitioners over how the body of technical

knowledge is utilised, and as importantly, the authority to exercise control over their own work and that of others (Freidson 1970; also see Johnson 1972).

The importance placed on autonomy is also reflected in alternative definitions of professionalism. For example, Tolliday (1978: 44) identifies four characteristics of medical profession activity. These are: the right to independent practice; the right to refuse an individual patient; the responsibility to lead and co-ordinate other health professionals; the over-arching primacy of medical knowledge. Similarly Light (1995), suggests that professional dominance of medicine can be defined in terms of an aggregate of a number of different dimensions: clinical autonomy; fiscal autonomy; practice autonomy; organisational autonomy; organisational control; institutional control. Elston (1991) sums up a variety of classifications of the ways in which the autonomy of medical professions may be exercised over work activity. She agues that three main categories are reappear:

> economic autonomy, the right of doctors to determine their remuneration; political autonomy, the right of doctors to make policy decisions as the legitimate experts on health matters; and clinical or technical autonomy, the right of the profession to set its own standards and control clinical performance, exercised, for example, through clinical freedom at the bedside, professional control over recruitment and training or collegial control over discipline and malpractice (Elston 1991: 61-62).

Furthermore, Elston makes the interesting point that it is unclear how changes in one type of autonomy would affect the others. This is a question that has important consequences for international comparisons of medical dominance in national health systems. Moreover, it becomes a central problem of empirical investigation when considered in the context of contemporary professions literature that posits that medical dominance, and therefore autonomy, is in decline or at least undergoing profound changes. The principal agents of change are seen to be those charged with preventing health spending from 'getting out of control'. In many health care systems the agents of control are aligned with state organisations, and in the case of the NHS, part of the machinery of government. At the other extreme, in market systems such as in the US, the impetus for change comes from third-party-payers, be they private

insurers or the state. Either way, the state plays a key role in all Western health care systems. But what is unclear is the relationship between the state and medical authority and autonomy. Does the medical profession play an essential role in the organisational structures of the health care system (Freidson 1994; Light 1995)? Or are medical professions now facing the fate that has befallen professions of the past, the inexorable process of 'proletarianisation' and 'deprofessionalisation' as is the nature of capitalism? (Oppenheimer 1973, McKinley and Arches 1985; Haug 1975, 1988; Haug and Lavin 1983; Starr 1982). A governmentality analysis provides no ready answer, since both alternatives are possible. All is dependent on how governance is articulated at a particular time. In the previous chapter, expertise, and therefore professionalism and autonomy, were presented as being functionally important to liberal forms of governmentality. But, as mentioned earlier in this chapter, this does not mean that particular forms of expertise, and that includes medical expertise, will not be under threat when the formula of liberal rule changes. Therefore, it be useful to examine the empirical evidence presented in the professions literature to see if insights can be obtained into the future status of the medical profession.

Medical autonomy and the State

At the heart of any discussion of medical autonomy, and professional activity in general, there is a conundrum. If one returns to the classical idealised concept of the 'liberal profession' as the foundation of all professional activity, in essence one sees the simple relationship between practitioner and patient. However, as Harrison and Schulz (1989) point out:

> In the idealised nineteenth-century liberal concept of medicine and commerce, there are no third parties; there is only the direct relationship between the patient and his or her independent family practitioner. In such circumstances, clinical autonomy is not held to be an issue, since both parties have freedom of choice over whether to continue the relationship (Harrison and Schulz 1989: 199).

As the above highlights, autonomy can only be said to have meaning when there are organisational structures that have the potential to circumscribe professional action.

Harrison and Schulz go on to suggest that this idealised presentation of professional activity has to be tempered by the historical facts. Medicine has always operated with input from third parties 'in the form of hospital owners, friendly societies and the like' (ibid.: 199). In the modern era medicine has become more and more implicated in elaborate organisational structures and therefore, clinical/medical autonomy becomes a more pressing issue.

However, there is another fundamental point to be made about the relationship between practitioners and outside agencies. This is especially important when that external agency is the state. For example, Johnson (1995) suggests that even in very sophisticated accounts of the process of professionalisation, there is a paradoxical relationship between state and the profession that is the source of dispute and controversy in the professions literature. As Johnson argues:

> ... there is little doubt that a significant source of such disagreement (and, one might add, mutual incomprehension) is the pervasive conception of state/profession as a relationship between preconstituted, coherent, calculating political subjects; one intervening, the other seeking autonomy. While the professions are seen as acting to maximise autonomy, the state is presented as continuously extending its apparatuses of control throughout society, including over professions (Johnson 1995: 9).

The paradox occurs because the state is seen to provide a 'shelter' (Freidson 1994: 83), a protected space in which the profession can organise and flourish. This is because, for some occupations, it is accepted that the tasks which are undertaken 'are evaluated as being of such importance to the public good that leaving them unregulated would be undesirable' (ibid.: 84). In effect, this relationship between the state and the profession defines the boundaries of professional activity. Inside this boundary those licensed by the state, and therefore considered to be professionals, are free to organise and exercise autonomous control over the application of technical knowledge and the resultant division of labour. Furthermore, within this space created by the state, the profession is given the authority to police its own members as well as control entry into the profession itself by a process of credentialism. Outside the state/profession boundary the state reifies this arrangement by the enactment of

legislation. The important point to note is that legislation is not necessarily part of a process to make alternative forms of practice illicit. Individuals, or organised groups of practitioners, may still occupy the same fields of activity as licensed professions, utilising the same knowledge base or an alternative body of knowledge. What the legislation prevents these alternative practitioners from adopting is the unequivocal authority of a 'profession'. But, at the same time, this limited acknowledgement by the state of alternative practice, does not prevent the licensed profession from denigrating non-professionals with whom they are engaged in a form of competition. From the nineteenth-century onwards, the medical profession has been engaged in a ceaseless task of uncovering all forms of 'quackery' that pose a threat to established practice, or lack the supposed scientific rigour of orthodox medicine (Stacey 1988; Larson 1977; Larkin 1995). The medical profession can only mount this challenge because of the shelter, and legitimacy, provided by the state.

In many ways these notions of a professionalism 'dependent on its dependence on the state' (Johnson 1995: 10), are not too dissimilar from the concept of expertise and the role it plays within governmentality analysis. As Johnson goes on to point out, in his analysis of Freidson (1970; 1973), Larson (1977) and Abbott (1988), there is a common notion of professionalism being constructed ideologically by its interaction with the state, that professions 'should not be viewed as stable and fixed characteristics' (Larson 1977: xii). Thus the definitions of Freidson and Tolliday stated earlier, are more a definition of how professions see themselves than outlining the essential nature of professions. Nettleton (1995) reinforces this point, suggesting that 'simply listing the characteristics that are identified by the professions themselves merely reflects and reinforces their ideas and values' (Nettleton 1995: 196). Freidson (1995) also makes this observation, noting that the esoteric and complex technical knowledge that forms the basis of professional identity is not immune to being ultimately broken down into simple tasks and standardised. It is not desirable, in certain circumstances to do this, Freidson agues, because when:

> ... some of the consumer's needs are reduced to standard categories, thus reducing the consumer to a standard object, this may seem oppressive and disabling. I think it can be argued that the producers of some goods and services should be able to exercise discretion and

> judgement not only for the sake of their own humanity, but also for the sake of the humanity of the consumer (Freidson 1994: 165).

It can be argued that here Freidson is presenting a way of conceptualising professionalism that is not too dissimilar from Foucault's use of expertise within governmentality. One could make the case that professionalism and expertise are inextricably linked with liberal political philosophies. The connection is reinforced by Freidson's observation that 'the theoretical literature on the professions is almost wholly Anglo-American' (Freidson 1994: 19). Professional activity, as with expertise, appears to play a role in liberal society, but that role, however defined, is contingent and presumably historic, in that the construction of professional rationales can be investigated empirically in terms of uncovering the 'evolutionary' pathway in which profession are situated.

Where this differs from governmentality analysis is that Freidson, together with Larson and Abbott, present their analysis of professionalism, and the formation of professionalism, within a tradition that emphasises the duality of state and profession. For Freidson this comes about through the autonomy of technical knowledge, in Larson's analysis the state is a pre-constituted reflection of class power, and for Abbott the state provides the audience for professionals competing for jurisdiction. What governmentality suggests is that this emphasis on duality is misplaced. The governmentality argument for autonomy, expertise and professionalism, is similar to that employed in Chapter 3 when discussing the concept of the self-regulating individual within liberalism. In liberal forms of governance there is no opposition between individual freedom and the state, they are both aspects of a mentality of government that creates a bounded space in which a meaningful articulation of the process of governance becomes tangible. Likewise, professional autonomy in governmentality is not seen as being in opposition to state power. Professionalism together with the state are forms of governance. The construction of professional identity around the concept of autonomy is itself part of this formula of governance, in that it allows regulation of the population 'at-a-distance'.

The power of governmentality as an analytical framework is that it resolves the paradoxes inherent in dualist forms of analysis. Dualism presents the state as being both the protector of professional autonomy and, at the same time, a threat to autonomy as the interventionist state attempts to exert control over the profession. In governmentality there is no paradox because autonomy and the state are both part of the same articulation of governance. Whereas in dualist thinking professional autonomy is dependent on the dependence on the state, the governmentality formula conceptualises autonomy and the state as dependent on a particular mentality of liberal governance. It is the mentality of governance that is the dominant factor in determining the role of various forms of expertise. As argued earlier in the chapter, if the form of liberal governance changes then so might the range of expertise that forms part of the technologies of governance. As Johnson (1995) states:

> ... Because governments are dependent on the neutrality of expertise in rendering social realities governable, the established profession have been, as far as possible, distanced from spheres of political contention - the source of professional autonomy. However, because government policies and policy objectives change over time, these boundaries are in constant flux, having the effect of refashioning jurisdictions, breaking down arenas of neutrality and constructing new ensembles of procedures, techniques, calculations and roles which reconstitute the lineaments of the state itself (Johnson 1995: 22).

The governmentality argument also provides an answer to another paradox that emerges from international comparisons of health systems and the differing roles played by medical autonomy. Within dualist frameworks, in which autonomy and state control are in opposition, Döhler (1989) suggests 'the assumption that professional autonomy in particular is restricted by the integration of the physician into the machinery of welfare bureaucracies is not only a vital part of the credo of the medical profession itself, but also a commonly held opinion within the social sciences' (Döhler 1989: 180). As an illustration of this, the US health system with its minimal state intervention and well developed market in health care, has historically been characterised as representing an idealised form of clinical autonomy (Freidson 1970). However, in recent years, and contrary to this position, a number of writers have described a profession under threat, with reduced clinical autonomy, and perhaps,

ultimately, facing a process of deprofessionalisation (Haug 1975, 1988; Haug and Lavin 1983; Starr 1982). As Harrison and Schulz (1989) point out, medical professions in the US enjoy less clinical autonomy that those in the UK, but this has to be balanced against a great deal more economic autonomy. Even so, 'US physicians have accepted restrictions on their clinical autonomy which would be unthinkable to British doctors' (ibid.: 205). In essence, there seems to be no unambiguous mapping between the degree of state intervention in the national health care system and the amount of clinical autonomy possessed by medical professionals within the system. Indeed Döhler's (1987) comparative study of national health care systems and the degree of clinical autonomy enjoyed by the medical profession within them, supports this assertion. Using a typology that categorises health care systems by their 'organisational density', ie the degree of market dominance by the state or market in health care (the UK having a high density, the US a low density), she finds that 'there is no positive correlation between the degree of welfare state development and a reduced professional autonomy of physicians' (Döhler 1989: 195).

While the above problem is not impossible to resolve within a dualist framework, the fact that the problem arises in the first instance is indicative of the contradictions embedded in the framework, and which obstructs its potential for insight into the role of professions in regulating social order. In governmentality analysis these state/professions paradoxes do not occur, in that the state and the profession are basically two aspects of a form of governance. Professions are part of the regulatory process, which in turn, is part of a particular articulation of a formula of rule. In the case of the UK, in which the health system is part of an articulation of governance that gives rise to a form of welfare liberalism, then the regulatory role of medical professions can only be legitimised by emphasising the autonomous nature of practice and the altruism of the profession as a whole. The example of the US health care system provides a stark contrast. The articulation of governance that sanctions a market in health care and one that has little state intervention, in theory has no need to rely on the altruism of the medical profession. The market itself supposedly provides all the rigour necessary to provide a form of legitimisation of practice. The fact that the US market system is seen to be failing, that so many citizens have limited access to health care, and this is accompanied by ever increasing health care costs, is perhaps

indicative of the general problematic nature of free markets in health care. However, it is a sign of the power of the liberal articulation of governance in the US that the problem of inflationary health care costs (but not that of the inequalities inherent in the system), has developed to become part of the vocabulary of governance, in that it is seen to be a problem and therefore needs to be addressed. And it is the market which is looked on provide a solution - for the lack of any credible alternative articulation. In part, the introduction or appropriation of technologies directed by third-party-payer organisations are part of this solution. These include such things as case managers, diagnostic related groups (DRGs) and various forms of audit (see Chapter 3), all having the property of constraining clinical autonomy. In effect, they replace the assumed altruism of medical profession activity and re-constitute it through a market rationale, and become subject to technologies that produce a calculus of trust.

The comparison of US and British health care systems has an additional heuristic quality in that the US system does incorporate many of the important characteristics of neo-liberal forms of governance - the self-reliant individual responsible for their own health care provision and a health care system which is market based with minimal state intervention. In contrast to the US, the UK system, as represented by the NHS, is inextricably linked with a form of welfare liberalism. If the changes in contemporary UK health policy are thought of, as in governmentality, as reflecting a shift to a new formula of liberal governance, ie a form of neo-liberalism, then the study of US 'third party payer' technologies may be useful in acting as an early warning of their introduction into the UK. The existence of such technologies could well form part of the vocabulary of a new form of governance for UK health care. Additionally, the shift to a new formula of liberal governance will involve a re-articulation of relationships between the instruments of governance, such as expertise, and those subject to them. In the case of medicine as practised in the NHS, this implies new forms of relationship between medical profession and patients, with professional peers and other professions within the medical discipline, and with new organisational structures given the authority to manage the health care system.

Medicine, and the public and the decline of medical authority

There are many aspects to the relationship between medical professionals and their patients - class, gender, race - but perhaps the most basic derives from the utilisation by professionals of an esoteric, technical knowledge. It was argued earlier that 'ownership' of this kind of knowledge is regarded by many commentators as fundamental to the process by which some occupations achieve the status of professions. One of the mechanism that underpins this transformation, and sustains the profession once established, can be identified in the concept of the indetermination/technicity (I/T) ratio famously associated with Jamous and Peloille (1970). The practice of medicine is deemed to have a high I/T ratio by virtue of the assertion that the application of medical knowledge involves a great deal of intuitive thinking on the part of the clinician, and therefore, is not readily reducible to a standardised technical function. Hence the need for altruism in the definition of professional activity to balance the trust that necessarily has to be invested in the medical professional by the patient. However, what problematises this patient/professional relationship is the degree to which professions, and the knowledge on which they are founded, can be viewed as having been constructed and historically contingent, as the professions literature has highlighted. As noted in a previous section, Freidson (1995) suggests that even if the practice of expertise can be reduced to a technical exercise, some forms of knowledge, like medicine, are best administered in a professional context. Others have argued more critically that medical professional activity is not only constructed but that the process of construction reflects structural influences. For example, it is argued that medicine as a discipline represents dominant class interests within capitalist societies (Navarro 1976, 1978; Johnson 1977), or that the division of labour dominated by the profession is gendered (Stacey 1988; Witz 1992) and involves issues of race (Akinsanya 1988; Esmail and Everrigton 1993).

The additional effect of these criticisms is to call into question the 'neutrality' of the technical knowledge of medical science. Commentators have argued that not only is the division of labour within medicine gendered but that medical knowledge is gendered as well (Ehrenreich and English 1979; Oakley 1976). Another set of critiques calls into question the supposed effectiveness of curative biomedicine. Evidence of the

limits of modern medical practice is provided by McKeown (1976). As a result of a careful re-examination of the British epidemiological statistics McKeown demonstrates that the rapid declines in mortality in various disease categories have generally come *before* the development of medical technologies to counter them. And once introduced, the rate of decline tends to continue on the same downwards trajectory. This not to say that medicine is totally ineffective, just that the power of medicine tends to be greatly over-stated. This theme of effectiveness of medicine has also generated many powerful critiques of the power of the medical discourse. In an influential lecture in 1972 entitled *Effectiveness and Efficiency: random reflections on the health service*, Cochrane argued that far from being grounded in a scientific methodology, a great deal of common medical practice is unproven as to its effectiveness. Moreover, a great deal of medical research is poorly done, falling well short of the 'gold standard' methodology of the double blind randomised controlled trial. Taking this analysis even further, Ivan Illich (1975; 1976) suggests that medical practice might not only be ineffective but iatrogenic, that modern medical intervention is actually injurious to health. Illich argues that not only are many forms of medical treatment positively harmful, but that the discourse of medical practice takes away the capacity of individuals to take control of their own care and deal with pain and suffering.

The scepticism in curative biomedicine has increased in parallel with a society which is increasing less deferential to traditional forms of authority. Institutions once considered beyond criticism have come under public scrutiny and, from some quarters, have been the target of ridicule and vitriol in equally measure. The question is whether the critiques of the type outlined above that question the basis of medical knowledge and self-defined altruism, have added to a diminution of status for the medical profession. There is little doubt that the medical profession still retains a great deal of authority and in many ways recent government reforms have presented clinicians with the opportunity to enhance their position by appearing as guardians of the NHS public service ethos. However, there are a growing number of examples where one could argue that medical authority has been eroded. One such example is the growth in alternative forms of medicine and their partial acceptance as part of mainstream medical practice (Stacey 1988; Larkin 1995; 1995; Sharma 1992). Their growing

popularity could be seen as patient power at work and that an assertive, empowered public demands these therapies and therefore, they are supplied. The irony is that many alternative therapies are the folk medicines of yesteryear, the very same remedies once denounced as quackery by orthodox medicine. Many of the therapies also present a fundamental challenge to the biomedical basis of medical orthodoxy. They have a tendency to treat the body as a whole, often incorporating a spiritual element in the healing process, rather than just focus on physical sources of illness. Perhaps, it is telling of the inroads made by these 'alternative' forms of medicine that they are now classified by the British Medical Association (BMA) as 'complementary' medicine (Nettleton 1995).

Another illustration of a weakening of the medical hegemony can be found in the recent (May 1998) disciplinary inquiry by the General Medical Council into the competence of two senior consultant surgeons at a Bristol hospital, in respect of a number of the operations they carried out on very young heart patients. The essence of the charges brought against the surgeons is that they failed to re-assess their own practice once informed of the higher-than-average death rates that resulted from heart operations they were performing. This was a particularly emotive case which appears to be one more medical scandal to be added to a ever growing list of medical failure. In the UK, one can include thalidomide, the over-prescription of addictive painkillers and anti-depressants, HIV infection in haemophiliacs from contaminated blood products, failures of several cancer screening services, and all the other personal tragedies that do not make national news. However, what is important about the Bristol case is the response of the Government, and more notably, the positive response of organisations that represent medical interests, such as the Royal Colleges. The Government proposes a radical expansion of quality measures and audit, and that data generated will be published in some form, although at an aggregate hospital/speciality level. (The practice of audit will be discussed at the end of the chapter). What is significant is the tone of the debate surrounding the Bristol case, of which the Government announcement forms a part. Newspapers and their leader writers have generally portrayed this as a victory for the patient against the monolithic power of vested interests. The following is typical of the sentiment expressed:

> The oldest professional conspiracy is coming to an end... For years social reformers have urged policy-makers to introduce medical audit: an independent audit of individual medical competence. But the issue was so hot that the Royal Commission on Health, which reported in 1979, refused to look at the idea. Even the boldest of health ministers refused to push the plan. The Patient's Charter, launched six years ago, carefully restricted itself to administrative measurements. Yet, suddenly, Frank Dobson [the Secretary of State for Health] has stood up in defence of patient rights. By next October he intends to produce preliminary clinical indicators which will allow patients to judge their local hospital in relation to death rates after operations, heart attacks, and fractured neck [of femur] (The Guardian 11/6/98: 23).

What the Bristol case indicates is that much of the vocabulary of an alternative form of governance of health care already exists, it only needs a single event, or series of connected events, to begin a crystallisation of consciousness to form a coherent articulation incorporating that vocabulary. In the above, one can see various aspects of the vocabulary of neo-liberalism, especially the concept of the pro-active patient making informed decisions, who makes use of all relevant information in the manner of enlightened self-interested individual. There is a confrontation with a powerful organisation who 'conspire' to deny information to patients to protect their own interests. But most fundamentally, underlying all of these, is the concept that it may be possible to find the 'best deal' in treatment for the patient. The assumption is that there is an emergent market in health care, one not based on the exchange of physical goods, but one based on the concept of a free-market in expertise, 'where the relationships between citizens and experts are not organised and regulated through compulsion but through acts of choice' (Rose 1993: 296).

Medical professionals, expertise and markets

The juxtaposition of markets and expertise, especially in a context where expertise is being questioned, prompts speculation that the profession is undergoing a process of deprofessionalisation. The radical view is that it is undergoing a process of 'proletarianisation', based on the assumption that it is the nature of capitalism to seek control the labour market, and the labour process, to degrade skill and to reduce the

work process to a technical exercise (cf. Braverman 1974). The proletarianisation thesis, as applied to medicine, has its supporters (see Oppenheimer 1973, McKinley and Arches 1985). Clearly there is potential for some aspects of modern technology, such as computerised 'expert systems', to achieve a sort of Taylorism in medical practice. However, as Elston (1991) states "proletarianisation' itself remains unarticulated as a concept, making its applicability to the medical profession unclear... best regarded as a 'slogan' rather than an analytic concept' (Elston 1991: 64). For governmentality, this idea that proletarianisation remains 'unarticulated' is all important. By its nature, governmentality analysis can only remain agnostic about the way particular forms of expertise evolve, and perhaps, ultimately fade away. Proletarianisation is not necessarily incompatible with governmentality. If one strips away its theoretical underpinning and regards it as simply a process that leads to de-skilling of labour in the work process, it is an alternative that has to be considered. It is inevitable that some forms of expertise will no longer fulfil a regulatory role within a formula of governance and, therefore, will cease to be forms of expertise. The medical profession, at present, seems to have been spared that fate. The complex and indeterminate nature of health probably means that some kind of medical expertise will always be functionally important to liberal forms of governance. Therefore, the implications of a market in expertise has to be taken at face value. It is a market in which experts within one medical discipline compete with each other and, at the same time, with other novel forms of medical expertise that emerge.

The concept of a market in expertise prompts two further questions. From where will these new forms of expertise/professions emerge? And what will be the currency of exchange in this market of expertise? A partial answer to the first question has already been touched upon earlier. It is quite possible that some of the more established forms of practice within alternative/contemporary medicine, such as osteopathy or acupuncture, will make the breakthrough into mainstream medicine. Another source of competitive expertise will develop as the medical division of labour becomes less dominated by the clinicians. For example, we may see the increasing influence of pharmacists, especially in the introduction of high cost drug therapies such as β-interferon. However, the most notable source of competitive expertise will come from the challenge to patriarchal medicine, most significantly from nursing. This will in

effect reverse the assertion of Stacey (1988) that, 'the empirical evidence is that historical occupations which have made successful claims to be professions, which have gained work autonomy and become dominant, have all been male occupations; those which have succeeded less well...have been female or female-dominated occupations' (Stacey 1988: 80). However, the majority of competition will be between clinicians. And in answer to the second question posed earlier, the currency will be their ability to demonstrate 'effectiveness'. The basis of effectiveness will be defined within an audit process. Therefore, the nature of the audit process will be crucially important as it will, in turn, reflect the values of those that set the criteria of effectiveness. The problem now becomes transformed into one of who controls these criteria. Will it be clinicians or health care managers?

Medical professions, management and audit

The relationship between clinicians and managers/administrators within the NHS has always been problematic. (The evolution of new management structures will be described in more detail in Chapter 6). However, within the context of this chapter, several relevant points can be made. This first point, which has been made in previous chapters, is that the British NHS is quintessentially an organisation that reflects a 'welfare liberal' form of governance. The organisational structures of the NHS reflect the bargain between medical profession and the state, that 'while central government controlled the budget, doctors controlled what happened within that budget' (Klein 1995: 75). Thus 'the price of preserving clinical autonomy - the right of individual doctors to do what they thought right for individual patients - was accepting the constraints of working within fixed budgetary limits' (ibid.: 75). Clearly this formulation of the professions/state relation creates difficulties for those seeking to manage the service. Within a governmentality framework, one would expect that the closer that organisations employing expertise are identified with the state, the more autonomy granted to practitioners of that expertise, and the less power of oversight for managers. In other words managers would act more like administrators, making sure the system runs smoothly rather than having any strategic input. This is ably demonstrated by the excerpt below from a document outlining management structures envisaged by the 1974 NHS reorganisation:

> Success in achieving this aim [improving health care] depends primarily on the people in the health care profession who prevent, diagnose and treat disease. Management plays only a subsidiary part, but the way in which the Service is organised and the process used in directing resources can help or hinder the people who play the primary part (DHSS 1972: 9).

The inherent difficulty with this arrangement is that it leaves management in the unenviable position of being held to account for spending commitments for which they are not responsible, with clinicians responsible for spending commitments for which they are not accountable. And as the majority of spending is dependent on decisions made by medical professionals, then this will be the source of great difficulty for a government trying to contain costs. The problem for governments of all political persuasions is that it appears that it is an innate property of any formal health care system for cost to rise uncontrollably. In the 1970s and 1980s, the government found itself 'caught between the rising demands on the NHS generated by technical change and the ageing of the population, on the one hand, and the financial commitment to restraining growth of public expenditure, on the other' (Klein 1995: 131). Inevitably, the perception of the NHS as somehow 'failing' the British people inevitably results in it becoming even more politicised. The question is whether the politicisation of the NHS reflects a shift in the articulation of governance, or whether it is part of a process that *forces* a shift in the articulation of governance. On the whole the former seems the more likely option, although there is no reason why reaction to exogenous factors should not produce the same outcome. However, it can be no coincidence that the 1970s and the 1980s saw the rise in influence of Monetarist economic theories that makes a fetish of the control of public spending and minimal government - all the hallmarks of neo-liberalism.

For a government faced with rising costs in the NHS, the opportunity presents itself for devising innovative ways of managing the health care system. Many of technologies utilising the incorporation of clinicians in the management process and devolving some budget control, have been around for many years in one form or another (Harrison and Pollitt 1994). However, they were given a radical new impetus, in form of

'management budgeting', by the Griffiths Report of 1983. For many commentators the Griffiths Report represents a watershed in the history of health reforms in bringing management of the NHS onto the agenda (see Klein 1995; Cox 1991). The report, with its call for a more strategic management that engaged in budgeting and resource management, also called for more involvement by clinicians in the managerial process. But the report also suggested that it is the function of management to control the division of labour in the health services, and by implication, that would involve the division of labour that includes clinicians. In many ways the Griffiths Report presents some difficulties for a governmentality analysis. The business background of the most of the group that produced the report - Griffiths himself was deputy chairman and managing director of the Sainsbury's retail group - is seminal in introducing into health care management the language of commerce. As Cox (1991) states, 'the recurring themes of Griffith's managerialism are action, effectiveness, thrust, urgency and vitality, management budgeting, sensitivity to consumer satisfaction and an approach to management of personnel which reward good performance and ultimately sanction poor performance with dismissal' (Cox 1991: 94). It is the purpose of management to lead, to set goals, monitor input and output, ensure an effective workforce, strive for quality and efficiency, the minimum necessary for a successful firm to withstand the rigours of a market environment. Therefore, it would be reasonable to regard the Griffiths Report as reflecting a shift in the articulation of liberal governance. Yet, this is sustainable only to a degree. At the heart of the report, the incorporation of clinicians into management structures, is a solution that comes from an articulation of welfare liberalism. It does not re-articulate the problem in such a way as to negate it as a concern. Nor does it, in any meaningful way, alter the relationship between the medical profession and the state. As such the exhortations to enter into management can be easily resisted by the profession as an alien concept. As Flynn (1992) points out:

> Evidently, then, all the different schemes, under different rubrics - Clinical Budgeting, Management Budgeting, Resource Management - have encountered major problems in securing changes in attitude, behaviour and culture that their advocates promote. The enduring issue is that of clinical autonomy versus managerial control. All of these experiments and initiatives necessarily involve significant changes in the role of the hospital doctor, and each of them requires incorporation (and possibly subordination) of professional staff in the management

> process. Not only are doctors faced with information about their clinical activity, the resources used and their costs, but they are now invited to take an active apart in evaluating cost-effectiveness, and making trade-offs between alternative practices (Flynn 1992:87).

The essential difficulty of incorporating clinicians into management is that it asks clinicians to take on a role outside their own definition of professional medical practice. One solution is to separate the functions between supply and demand, in effect create a market in health care, or in the case of the NHS something that resembles a market, ie a 'managed market' or 'quasi-market' (the origins of the internal market will be discussed in chapters 6 and 7). However, what is important to note is that a market structure can represent coherent solution to the problem of clinicians and management. Quite simply, it is to limit the role of clinician to those activities associated with the management of supply. The demand function is to be left to a strategic management, with input from dedicated public health clinicians.

The management of audit

In any organisational structure the generation of information is of central importance in monitoring the work process. Of all the technologies that already exist, the process of audit appears the most appropriate in generating that information. However, as with all technologies of management control, context is all important. In the NHS, as with the various types of management budgeting, many forms of audit have been used. The Confidential Enquiry into Perioperative Deaths (CEPOD) that began in 1986 is one example. There have also been other such enquiries into maternal and infant deaths. However, the post-Griffiths management initiatives re-invigorated the audit debate. The new approach to audit was illustrated by Medical Audit Paper No 6, *Working for Patients* (1989), where medical audit is defined as:

> '...the systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcomes and quality of life for that patient. Because a patient's primary concern is for a correct diagnosis to be made and for effective treatment to be given, medical audit must be central to any programme to enhance the overall quality of care given to patients in the NHS. An effective programme of audit will help to

> provide the necessary reassurance to doctors, patients and managers that the best possible quality of service is being achieved within the resources available.' (Department of Health 1989: 3).

On face value the main functions of medical audit appear straightforward. Ideas of 'effective treatment' and enhancing 'the overall quality of care' point to considerations of efficiency. Similarly, providing 'necessary reassurance' indicates concerns for accountability, achieving this 'within the resources available' shows some appreciation of costs - and by extension cost containment. However, the Working Paper goes on to suggest that medical audit should also have an educational function, in that it 'must form part of the training of junior staff' (ibid.: 4). Additionally, in a later document, the audit process is described as being 'essentially a professional matter...medically led', and as 'primarily an educational activity' (Department of Health 1991). Furthermore, despite the declaration that audit was no longer a voluntary activity, the only form compulsion is the injunction to clinicians, in particular consultants, that they *should* participate in some kind of medical audit with no punishment for those who do not attend. Thus these early techniques of internal clinical audit in the NHS contain no real sanctions, are centred on the education and socialisation of junior staff, set standards locally and deal with problems internally by peers not management (see Pollitt 1993; Black et al. 1989). Management were given powers to 'initiate an audit review', if necessary, and that it should be an 'external peer review or a joint professional and managerial appraisal of a particular service' (DoH 1989: 6). But the problem is that unlike the US, where external peer review is standard practice, in the UK there are no equivalent peer-review organisations. As Pollitt states, 'in the NHS there is, in effect, no external review' (Pollitt 1993: 164).

The one thing that is clearly problematic about the audit process as outlined above, is that medical dominance of audit does not produce quality information of use to health care commissioners. The confidential aspect of audit means that only abstract, generalised information reaches managers and commissioners, reducing accountability and weakening oversight (Kerrison et al. 1994: 156). Furthermore, former funding arrangements for audit 'whereby funds are ring-fenced and clinicians are not faced with having to justify the benefits of audit against other priorities for spending, have

contributed to a situation where audit is currently marginal in terms of time, commitment and priority.' (ibid.: 171). Therefore, the evidence suggests that, in this instance, audit is not yet a technology that belongs of a new articulation of governance. However, the use of audit in the US context does indicate that in can be seen as part of a neo-liberal form of governance. In the case of the US, the market in health care provides the legitimacy for the policing of standards by agencies outside the medical profession. Again, it is useful to note that accreditation and quality reviews have traditionally been part of medical professional activity and a mechanism of self-regulation. The system was simply adopted (and adapted) by those who contract for health care (see Harrison and Schulz 1989).

If audit had become a marginal activity then this is certainly not the objective set out for it in the Working Paper. This stresses that audit must be '*central* to any programme to enhance overall quality' (1989: 3; emphasis added). However, the accent is placed not on management control and cost containment but on achieving greater quality of care within resource constraints. Therefore, one could argue that notions of efficiency and effectiveness are fundamental to the audit process, not just in terms of volume of health care and cost-per-unit, but in terms of 'quality' outcomes that maximise patient welfare. The problems is of defining in any meaningful way what kind of 'quality' is to be pursued. It has already been noted that medical audit as practised in the NHS, is dominated by medical professionals idea of what audit should achieve, and thus 'quality' is couched in terms of medical values. But this emphasis on professional medical ideas of care need not be the sole measure of quality. Donabedian (1988) points out that there are more aspects to care than this - structure, interpersonal relationships, use of resources as well as technical care. Thus the purpose of audit is to encourage those medical practices which maximise patient outcomes defined in these broader terms which incorporate patient and social values. A measure of quality outcomes such as the Quality Adjusted Life Year (QALY) would be one (if limited) example (see Chapter 5). It is the nature of such measures that the cheapest practice is not usually the 'best practice', ie the most efficient practice. But neither is 'best practice' synonymous with 'ideal practice', the point being made is that '"ideal" medical practice cannot be achieved given limited resources, and that what we are striving for is "best medical practice" given the resources available' (Mooney and Ryan

1992: 180). Therefore audit should not be about making clinicians accountable for their decisions based on current practice but as a methodology whereby they are measured against 'best practice' and held to account for the differences between the two. As Mooney and Ryan observe, given 'the fact that, faced with similar patients, individual members of the medical profession differ so much in what they do...[t]hey cannot all be right' (ibid.). At the very least the audit cycle should be the mechanism which allows the clinician to think reflexively about their own practice.

The method of medical audit adopted by the NHS - internal peer review - is potentially very flexible. However, assessing audit in terms of the degree to which it encourages efficiency and effective practice, reveals some quite serious flaws in the audit design. If the purpose of audit is to compare current practice against 'best practice', then this will not be best done within an internal peer review structure. Internal review makes clinicians accountable to the implicit and explicit criteria of current practice, but it is not a process that easily lends itself to the exploration of alternative criteria of 'quality' health care. The typical audit practice of retrospective review of case notes is based on too small a sample to build up a systematic understanding of treatment and outcome. The emphasis on the education of junior staff within audit, compresses the audit cycle and does not allow for long term studies. As Kerrison et al. note, 'since medical audit is concerned with the quality of current practice, it is not identical with medical research' (Kerrison et al. 1994: 175). Therefore, audit cannot meet the challenge of the fact that 'many therapies in everyday use in all medical care systems have no scientific basis ie, they are of unproven benefit' (Maynard and Sheldon 1994: 7). As Bull (1991) comments:

> '...whereas clinical research attempts to demonstrate a direct causative link between processes and outcome, audit builds on the fact that such a link has been established. For the medical audit model to apply, the link must be clear and direct. There is little sense in auditing the outcome of care against a given standard if that outcome is not dependent on the quality of the care process. There is little sense in auditing a process of care against a standard if it is not known how or whether the process will benefit the patient.' (Bull 1992: 398).

Conclusion

This chapter has highlighted the importance of expertise - as embodied in professions - as a regulatory technology associated with liberal forms of governance. As part of the analysis of expertise within the governmentality framework there was a critical engagement with the more conventional professions literature. One of the key themes that emerged was the nature of the relationship between professional autonomy and state control. It was apparent that there was a clear divergence between governmentality analysis and those accounts that emphasised the duality of state and profession. Using the governmentality framework it was argued that in liberal forms of governance the autonomous profession and the state are both aspects of the same mentality of government. The construction of the concept of autonomy of expertise is itself part of a formula of governance, in that it allows regulation of the population within the private/non-political domain beyond the responsibility of the formal state.

The latter part of the chapter explored further the relationship of professional medical expertise with the state. In particular the relationship between the state and expertise within welfare liberal forms of governance. It was suggested that professional autonomy becomes more well defined the closer the state become associated with the delivery of welfare provision. Therefore, in welfare liberal forms of governance the autonomous profession plays an important function in regulating the population 'from-a-distance'. However, when the form of liberal governance changes so does the function of autonomous expertise and its relationship with the state. For medical expertise this may mean that accepted notions of professional altruism and expectations of trust are also challenged and new relationships with patients are formed. Similarly, the bureaucratic control of the health care system may involve new technologies of control, such as audit and peer review, that reflect a new articulation of health governance.

It was suggested in the chapter that, hitherto, no legitimisation is apparent in the UK that would allow direct scrutiny of individual clinical practice. However, most of the vocabulary is in place. The development of the work pioneered by Cochrane, and others, has continued and expanded. The post-Griffiths management initiatives, the

internal market, the increasing influence of health economics and academic research have all added to a re-coding of medical dominance of the NHS as a problem in search of a solution. It is in this context that more recent changes in audit, and the shift to a multi-disciplinary structure, can be viewed. From 1994-95 the audit money was no longer 'ring fenced', but distributed by Health Authorities in line with the audit priorities of the Authority, their commissioning intentions and problems identified from a number of source, both local and national. As Ranade (1997) points out, 'clearly these changes have tipped the balance of power further in a managerial and purchasing direction, and suggests a more important role for other professions in relation to doctors, although the DOH is acutely aware of the 'professional sensitivities' that have to be overcome' (Ranade 1997: 145).

The recent Bristol case mentioned earlier, and the radical government initiatives that followed, suggests that these 'professional sensitivities' are in the process of being overcome. Pollitt (1993) makes the prophetic observation that his experience was that while many individual managers privately rejected the idea that 'medical underperformance was a medical, not a management problem... few seemed to make an issue of it on principle. The preferred tactic was to await a suitable test case and meanwhile avoid an unnecessary policy clash with the BMA' (Pollitt 1993: 164-165). Perhaps Bristol provides that test case. Furthermore, the technologies associated with extending control over the medical profession, such as audit and effectiveness criteria, are essentially technologies of priority setting. The use of 'evidence based medicine' effectively has two related purposes; to control medical professionals and provide a technical/scientific rationale for setting priorities. The technologies of priority-setting will be discussed in the next chapter.

Chapter 5

The economic discourse of health priorities

Introduction

The decisions made by medical professionals continue to play a pivotal role in determining health care priorities. However, in the last two decades the question of setting priorities for health care spending has become an increasingly contentious issue in the *political* regulation of all state financed health care systems. Inevitably the debate revolves around the use of the 'R-word' - rationing. It is the purpose of this chapter to set out some of the key concepts within this rationing/priority-setting debate. However, a case will be made for placing the debate within a governmentality framework. The consequence of the shift in the articulation of governance from welfare liberalism to neo-liberalism is that rationales based on economic calculation come to the fore. The concept of priority-setting and rationing are part of this shift in the formula of governance. It re-codes and re-problematise the difficulty task for health care systems of matching health needs with the provision of health care so as to make it amenable to an economics discourse. This re-coding entails reinterpreting the provision of health care services historically as a form of implicit rationing. The new health economics discourse, in contrast, presents a form of explicit rationing as a reasoned response to the contemporary problem of maximising the benefits of health care for the whole population given limited resources.

To develop this argument there will be a brief discussion of the economics of health care and the related concepts of implicit and explicit rationing. The example of the Oregon Health Plan is used as an illustration of the problems and technologies associated with rules-based rationing. These technologies are further discussed in terms of their function and limitations as part of the rationing/priority-setting debate, especially the way in which they construct the subject of the health economics discourse. Finally, a critique will be presented of neo-liberal economics using the work of the American sociologist Mark Granovetter and his concept of the embeddedness of economic action in social relations. The additional benefit in discussing this work is

that it provides a key element missing from governmentality analysis. The concept of extra-discursive networks of social relations introduces a mechanism which allows the inclusion of contingent factors that modify the totalising discourses described by governmentality analysis. Granovetter's work also presents a critique of the totalising nature of economic models of behaviour when used as the basis for explaining all social behaviour (Becker 1976; Williamson 1975), both in terms of providing a 'rational' and moral basis for priority-setting agendas and the development of the institution in which these agendas are operationalised.

The economics of health care

It is held almost as an axiomatic principle that in the NHS demand for health care will outstrip supply many times over. It is almost as equally widely held 'that the distribution of health care should not be left to the market... market allocation has been described as socially inefficient, as damaging the doctor/patient relationship and reducing the scope for altruistic behaviour.' (Le Grand 1982: 23). The special nature of health care - with its monopolies, uncertainties, asymmetries of knowledge etc. - differentiates it from most consumer goods and services. As a result of this it is generally accepted that the supply of health care will not be brought into any semblance of equilibrium in a 'free market' mediated by price signals. Price, in these circumstances, does not carry sufficient information necessary for the consumer to estimate any increase in welfare through consumption. Therefore, supply and demand become defined in terms of 'need' rather than 'wants' and 'desires'. This is not merely a question of semantics. An individual denied access to a common consumer good may feel that they have been denied a fundamental right of ownership or consumption, but the rest of society may not agree. As Leonard Fleck points out, 'health care services are not simply commodities in the market, like VCRs, that can be *justifiably* distributed according to ability to pay' (Fleck 1994: 368; emphasis added). This is not to deny that distribution in the case of VCRs is innately fair, or that the market mechanism may indeed be mystifying some deep structural inequalities, but in market oriented economies this mechanism for allocating resources is at best seen as socially neutral. Consequently, if the provision of health care services is not based on a market price mechanism, the outcome is that any allocation of health resources is no longer value-

free. In essence, one is left with the profound problem that while free markets 'allocate' resources other forms of distribution imply rationing or priority-setting. Whether done implicitly or explicitly, rationing will always involve some form of value judgement. Acting rationally in an economic sense implies However, unlike the *justifiable* resource allocation in the free market as outlined by Fleck, it has been argued that there is no analogous theory of *just* rationing (Daniels 1993).

In the context of 'market failure' and the absence of a 'just' method of resource allocation, the provision of health care becomes a 'fundamentally moral or political problem, and only secondarily economic or organisational problem' (Fleck 1994: 386). Because the 'invisible hand' of the market does not operate in this instance, rationing (or priority-setting), has to be seen as reflecting ethical/moral values. The value judgements assigned to the various states of health that individuals and groups use to legitimise rationing decisions are inextricably linked with the conceptual models used to operationalise 'health'. As a result, policy decisions informed by specific sets of value judgements and their contingent health models, may result in quite different courses of action. Therefore, it is instructive to go back to the concepts of 'rationing' and 'priority-setting' and attempt to unpack them to see if they can clarify the situation, so it becomes evident whose values dominate and in which circumstances. As Klein et al. (1996) suggest:

> ... the use of the word rationing should itself be strictly rationed. It should be reserved to describe the process by which resources are allocated to individuals at the point of service or programme delivery, while 'priority-setting' should be used to describe the process of determining budgets, and their distribution, which constrains the decisions about who gets what. Semantic pedantry will, in this case, help to clarify the argument (Klein et al. 1996: 7).

This way of framing the rationing/priority-setting debate differentiates between macro and micro levels of analysis. Rationing occurs at the micro level when actual decisions are made on the use of resources as they relate to particular individuals. By their nature these decisions will involve input from medical professionals and, to some extent, are dependent on notions of autonomy of action and the proper use of technical expertise discussed in Chapter 4. At the other extreme, priority-setting occurs at the macro level

with the setting of global budgets for health care by the authority of governments. Two points can be made here. The first is that in health care systems where, unlike the NHS, funding is not solely dependent upon taxation revenues collected by central government, control over setting the level of the health care budget becomes blurred as disparate agencies define their own priorities. The second relevant point is that a great deal of spending by government other than on the organised health care system also has an impact on population 'health'. The work of McKeown (1976) mentioned in the previous chapter emphasises this point, that the determinants of 'good health' are as much to be found in the provision of an efficient sanitation system and clean water as in direct medical intervention.

In addition to the above, one aspect of the rationing/priority-setting debate which has not yet been touched upon is the analysis of priority-setting at the *meso* level. This is the level at which health care managers (as purchasers) are the main actors. In health care systems such as the NHS where budgets are fixed by central government, it is at this meso level that a further refinement of health priority-setting takes place. The global funding is subdivided, by whatever means, so as to meet micro rationing decisions. However, the key to understanding the processes that take place at this meso level of priority-setting again relies on another invocation of 'semantic pedantry' to clarify the situation. In this instance, it is in making the distinction between 'managing' and 'administrating'. As outlined in the previous chapter, the role of the NHS manager through most of their pre-Griffiths existence was to offer administrative support for the activities of those that play the 'primary part' in preventing, diagnosing and treating disease, ie medical professions, and not to be active in setting and managing the priority agenda (DHSS 1972; 1979).

However, in this formulation of management responsibility there is an implicit understanding that the expected direction of influence - macro and meso decisions defining the boundaries of micro rationing possibilities - is reversed. In effect, the aggregate of micro rationing decisions defines meso level priority-setting, which is in turn *administered* by health service managers. Without a strategic health management structure to act as a buffer, this process leaves central government open to direct pressure from medical practitioners for more funding. This is usually achieved by

highlighting the perceived failings of various parts of the health system to meet patient needs - so called 'shroud waving'. As Klein et al. (1996) point out, 'if health care professionals succeed in convincing the public that the NHS is on the point of collapse because of inadequate funding - as they have attempted to do roughly every three years throughout the NHS's existence - governments are apt to turn generous, particularly when an election is looming' (Klein et al. 1996: 98).

Whether these demands are met or withstood is not the substantive point to be made. The more significant aspect of this process is the symbolic language in which this particular rationing/priority-setting debate takes place. It tends to be emotional, confrontational and highly political, and importantly is not about rationing itself but about the size and adequacy of global budgets for the health care system. The problem for governments is that this politicisation of the priorities debate cannot go on indefinitely. There are pressures on spending from exogenous variable such as ageing populations and the inflationary health care costs associated with use of high technology medicine. Adding to this is the evolutionary process in health care that means that some therapies and medical interventions once considered experimental and uncertain become, in time, 'taken-for-granted' and commonplace forms of treatment. Often they cease to be 'health' concerns and become a part of environmental or social policy, as in the case of providing an efficient sewage system or water supply. The result is that 'each time government steps toward the target of 'health' the thing escapes over the horizon, leaving behind only technical problems and arguments over resources' (Osborne 1997: 180).

The reform process in the NHS initiated by the Thatcher government in the 1980s, can be seen as an attempt to address the problem of limited resources and unlimited demand and the political difficulties this causes governments. However, from the 'governmentality' perspective, it is more cogent to view the rationing debate as a consequence of a shift in the in the articulation of liberal forms of governance from a welfare liberal formula to that of a neo-liberal form of governance. This is not to say that pressures on public spending as the post-war boom ground to a halt, and the increasing political fallout from trying to control health care cost in the NHS, were not significant factors in the shift to a neo-liberal form of governance. But what is

interesting is the way in which the discourse of economic 'crisis' in the early and mid-1970s coincides with a re-problematisation and re-coding of resource allocation for health care so that the concept of rationing emerges as central to the academic debate on providing health care for the population (see Klein et al. 1996). This emergent 'neo-liberal' articulation of governance, with its emphasis on the primacy of the 'market' in the political economy, generated new forms of concomitant expertise within the academic debate about the efficient use of resources. One such emergent form of expertise is that of the health economists. As Nettleton (1995) observes:

> Since the late 1970s the health system has witnessed the emergence of a new occupation group - the health economists. Prior to this time such a professional community did not exist, but with the escalation of health care expenditure, the emphasis on efficiency and a recognition by governments that health professionals should be encouraged to monitor their own performance in terms of the economic consequences of their behaviour, the time was ripe for their entry onto the stage of health care (Nettleton 1995: 222).

The idea of 'rationing' and the rise of health economics are thus essentially two aspects of the same (rational economics) discourse. The very concept of rationing is economic in origin. The ideas of allocative efficiency, of market failure in the provision of health care and the ethical problems of distribution of health care resources all stem from the problematisation of health care as an economics discourse. One of the most important points to be made about economic analysis is that the counterfactual argument is often invoked. In economics this usually entails stripping away inconvenient 'social factors' so as to uncover the structures that would obtain if an idealised, totally free market were possible. The problem of market failure makes this difficult health care systems. However, the basic understanding that follows from this use of the counterfactual is that if no market exists then the allocation of resources will, almost certainly, be allocatively inefficient. That is not to say that the system may be productively inefficient. One could imagine a factory somewhere that was a paragon of efficient organisation yet produced unusable articles. However, in a market environment this factory would quickly disappear - if it could get started in the first place. But in situations of command economy, as in the former Soviet Union, state sponsorship or political expediency could allow the factory to remain open indefinitely. This analogy is

directly relevant to the NHS. It too has historically been characterised by its command economy structure. Therefore, one could speculate that even if it was productively efficient it is unlikely that the priorities it embodied would meet the real needs of the population. The use of the counterfactual does not lead to suggestions that market failure can be overcome and an ideal solution can be achieved where rationing becomes transformed into 'neutral' allocation. What it does indicate is that any reform process that moves the health care system towards this economic nirvana will not only meet the needs of the populations more efficiently but that the reforms are also morally justifiable. The problem with this rationale is that in giving a basis for altering the status quo - the system dominated by medical professionals - it also creates the danger that the formerly implicit forms of rationing that distanced the government from making hard choices become explicit and thus become directly associated with macro and meso level priority-setting. Far from being value 'neutral' and apolitical, the process of making priority decisions becomes intensely political and unstable.

Strategies for rationing health care

By definition, rationing and priority-setting are inevitable in all health care systems. If there is no free market in health care then there has to be rationing and priority-setting. However, there are voices in the in the priority-setting debate which suggest that rationing/priority-setting <u>is</u> avoidable given enough resources or more effective or efficient use of the money already provided for health care. As Roberts et al. (1995) argue, 'those who passively accept that 'rationing is inevitable' have not thought it through... The main obstacles to change... are the workforce's cultural resistance and vested interests, weak management, and frequent political interference. These obstacles must all be tackled. Until then rationing health care is unjustifiable' (Roberts et al. 1995: 15). Such comments have variously been dismissed as 'naïve, misleading and manifestly incorrect' (Zimmern 1995: 19) or a 'glib prescription' (Paton 1996: 36). However, rather than misrepresenting the situation, Roberts et al. appear to be basing their argument on a different conceptualisation of rationing - that rationing means *explicit rationing* - hence the confusion. That rationing/priority-setting has always been a part of the NHS, is again a statement of fact, not argument. The problem for Roberts et al. is that they are not engaging in an *economic* debate about rationing, nor do they

acknowledge that historically rationing has always been part of providing health care in the NHS, but that it is done implicitly not explicitly. This tension between implicit and explicit forms of rationing is central to the political debate about priority-setting and therefore, needs to be explored in more depth.

To illustrate the differences between implicit and explicit rationing, and who makes rationing/priority-setting decisions, one can turn to the series of rationing strategies outlined by Klein et al. (1996: 11-12). Building on the work of Parker (1975), Klein et al. distinguish between seven forms of rationing strategy:

Rationing by denial. Whereby individuals are refused treatment because resources are limited or they do not fulfil the predetermined criteria of eligibility.

Rationing by selection. This occurs when certain individuals are selected for treatment because it is assessed that they are more likely to benefit from the treatment than other individuals.

Rationing by deflection. In this form of rationing health 'needs' are re-coded as best suited to intervention from non-health care agencies. For example, care of the elderly becomes the remit of Social Services not the health care system.

Rationing by deterrence. This includes a range of strategies that substitute outright denial of services with the erection of barriers to access. These include limiting information about available treatments, making the selection process onerous and time consuming or that the patient has to convince a 'gatekeeper' that treatment is justifiable.

Rationing by delay. To act as a buffer and control demand, waiting list are used or a lengthy process has to be gone through in order to secure treatment. In these circumstance, the individual client can be offered the services they need but only when resources become available

Rationing by dilution. This form of rationing functions by offering a range of services to which all have access, but the quality of the service may be compromised by limited resources allocation, which results in fewer tests being performed or less rigorous examinations undertaken and so on.

Rationing by termination. The remaining option if all else has failed is simply not to offer the client the treatment or services on the grounds that it would not be effective in their circumstances or that all possible alternatives have been exhausted and there is no more to offer.

One form of rationing not described in the above list is **rationing by price**, where the individual simply cannot afford the cost of treatment or the cost of health insurance. This is more relevant to the discussion in a later section of the chapter dealing with health reforms in Oregon, USA. However, it is relevant to this discussion of rationing strategies in that the absence of rationing by price indicates that the above list is more appropriate to understanding rationing policy in state controlled, or sponsored, health care systems. Taking the NHS as an example of such a system, it is evident that many of these strategies are employed in the health services as a means of controlling demand. Of these, the most prominent - rationing by deflection, deterrence, delay and dilution - can be categorised as *implicit* form of rationing. The tendency is for such rationing decisions to be made at the micro level, by clinicians, and be partially obscured by the confidential doctor/patient relationship. The concept of implicit rationing and the role of clinicians will be examined in the next section.

The case for implicit rationing

As noted earlier with reference to Roberts et al. (1995), rejection of explicit rationing policy often reflects a failure to recognise that health care provided by the NHS has always been implicitly rationed and that as a result of the dominant position of medical professionals in the NHS, that the main agents of rationing are the clinicians themselves. The role of GPs as 'gatekeepers' to secondary care, clinical autonomy and waiting lists combine together to become the main mechanism of rationing in the NHS

(Harrison 1995). As Harrison points out, 'clinical freedom' allows clinicians to 'reclassify some patient demands as 'needs' whilst (often subtly) rejecting others; it seems likely that clinicians alter their perception of 'need' in the light of available resources, though they do not always recognise that they are so doing, or think of it as rationing if they do recognise it' (Harrison 1995: 886). Therefore, it gives the *appearance* that rationing is not taking place. However, the reality from an economics perspective is of a rationing process that is implicit, unsystematic, ad hoc and probably conditioned by unconscious biases. As Mechanic (1995) observes, 'implicit rationing is seen to suffer from the discretion it gives doctors who may act on personal preferences or ignorance of medical advances. Social judgements are readily confused with subjective judgements of medical necessity and preferences creep in unconsciously, reflecting class, sex, and other social biases' (Mechanic 1995: 1657).

However, as Mechanic argues, the alternatives to implicit rationing - rules based explicit rationing - are far from perfect. The reliance on the use of counterfactual arguments gives rise to the 'illusion that optimisation is possible' (ibid.: 1659). Echoing this, the classic formulation of the 'tragic choice' by Calabresi and Bobbit (1978) also posits that rationing is not conducive to unemotional analysis, ie rational analysis. This is especially true when lives are at risk, particularly when known individuals are at risk, such as the Child B case in the UK. The Child B case concerned a young leukaemia sufferer - Jaymee Bowen - whose father unsuccessfully took the Cambridgeshire Health Authority to court to force them to fund further treatment that was denied on the grounds that it would be of limited effectiveness and detrimental to her quality of life (see Price 1996). The resonance of this case was amplified by seeing her as an individual who was suffering, and as Hadorn argues, it feels immoral to 'stand idly by when an identified person's life is visibly threatened if effective rescue measures are available' (Hadorn 1991: 2219). This 'rule of rescue' appears to be a natural human instinct. The urge to rescue trapped mountaineers or astronauts stranded in space feels natural, even when directed at non-humans, such as stranded whales. Many of these interventions are extremely expensive and often futile, but very rarely is the cost of these actions questioned. However, when this 'rule of rescue' is applied to health care with its limited resources, these questions arise all the time. Allocating resources to treat some individuals implies that their lives, or quality of life,

has a higher value for society than for other individuals. Explicit rationing exposes this value judgement. Calabresi and Bobbit argue that implicit forms of rationing have a social virtue over explicit forms of rationing in that 'evasion, disguising, temporising, deception are all ways by which artfully chosen allocation methods can avoid the appearance of failing to reconcile values in conflict' (Calabresi and Bobbit 1978: 22). As Hall (1994) states:

> Bringing rationing decisions into the full light of public deliberation will only heighten their tragic nature and thus disable us from making them or inflict greater social grief in the process. The more forthright method may not be the more socially desirable one (Hall 1994: 325).

The notion that explicit rationing is socially corrosive is particularly relevant to health care systems that reflect a form of social solidarity, such as the NHS, which are funded by social insurance and privilege equality of need as the principle of allocation. Unlike private insurance arrangements, the NHS does not guarantee treatment, it aspires to provide appropriate treatment given adequate resources. Explicit rationing threatens to undermine this convenient fiction of equitable treatment. It removes legitimacy from the system of health care provision, and in uncovering the rationing mechanism, it threatens the relationship of trust between the patient and doctor. That relationship is based on the tacit agreement that the doctor has the best interests of the individual patient at heart and is not preoccupied with how funds are allocated (see Mechanic 1995). If explicit rationing is to work it must incorporate new mechanisms for re-establishing trust, between the patient and the medical professional and with the system as a whole. To judge whether this is possible we must see rules based rationing in practice. Conveniently, the 'Oregon experiment' provides such an opportunity.

Explicit rationing and the Oregon Health Plan

The state of Oregon in the USA has been the focus of world-wide attention for its bold use of explicit rationing methodologies in setting health care priorities (see Buist1992; Honigsbaum 1991). However, before going into detail about the Oregon programme it is relevant to point out the different context the US provides in terms of a health care systems. In the US there are three forms of health cover: **private insurance**, financed

by the individual, usually accompanied by employer contributions; the **Medicare system**, which is federally funded and is open to those 65 and over; and finally there is the **Medicaid system**, a state funded health care entitlement for those citizens that fall below a specified income *and* fit into other specified categories, such as families with dependent children or the disabled (see Kitzhaber 1993: 374). Unfortunately, many US citizens do not qualify under any of these schemes. This group may account for 15% of the population, some 37 million, many of whom have very low incomes. This is not counting those that are inadequately insured to meet foreseeable health needs (Buist 1992; Goldberg 1994). Additionally, Medicaid, being a state funded system, has in most states been targeted to meet the financial pressure to cut the cost of state government. The result is that the cut-off income for eligibility for Medicaid in all states has decreased in recent years. In Oregon in 1989, just before the enactment of the Health Plan, the cut-off was 58% of federally-established poverty level (FPL), this placed the state just below the national average (Dixon 1991). The ambitious objective of the Oregon Health Plan was to meet this challenge of limited health care to 'assure every Oregonian access to health care coverage' (Paige Sipes-Metzler, Director of the Oregon Health Services Commission 1994). The principal aim of the Health Plan is to achieve these ends not by increasing funding but by introducing a robust methodology of rationing that would allow existing resources to provide a 'basic health package' for all those without insurance and which would act as a baseline for those with private insurance. Therefore, together with Medicare provision for the 65s and over, practically all citizens could have some kind of health care coverage. In part, the Health Plan can be viewed as the consequence of failed attempts to ration in the past. In 1987, it was decided by the state Senate, under the direction of the then Senate President, John Kitzhaber, to prioritise Medicaid resources to alleviate the state's high infant mortality rates. As a consequence, it was decided to stop state funding of most forms of transplant surgery. Unfortunately, a seven year old boy, Coby Howard, fell foul of this little noticed ruling and subsequently died due to the lack of funding for a bone marrow transplant. The case, like that of Child B in the UK, became a high profile *cause célèbre*. However, rather than abandoning attempts at targeting the Medicaid budget, the political response was to formulate the Health Plan.

The basis of the Health Plan was the appointment of a Health Services Commission made up of a diverse, non-political group of individuals who were given the remit to oversee the process of devising a methodology to decide health care priorities in the state in a manner that would be clear and open to public scrutiny. Their initial action was to draw up list of health conditions using a recognised international classifications of diseases and their treatment in order to form a series of condition/treatment pairs. It was then decided by the Commission to rank the condition/treatment pairs using a Quality of Well-Being (QWB) scale of the type developed by Robert Kaplan. The scale gives weight to post-treatment quality of life in the form of a single index number. The condition/treatment pairs were sifted and ranked after consultation with local interest groups at open public meetings and the final list costed by an actuary. The generation of several notable anomalies in the ranking list of conditions and their treatments provided an early problem for the Oregon methodology. The Oregon commission had to revise their prioritisation criteria several times to eliminate the more egregious priority rankings - treatments for thumb sucking above life-saving appendectomies for example. Ironically, the initial lists included a very low ranking for many types of bone marrow transplant, so low they would almost certainly have been excluded from funding without the revision process (Hadorn 1991; Buist 1992). Eventually a final costed and ranked list was produced. Inevitably there had to be a cut-off point below which some treatments could not be allocated funding from the global budget. The cut-off point in 1991 was 587 in a list of 709. Using the Klein categorisation outlined earlier, the Oregon Health Plan could be characterised as 'rationing by denial'. Anyone needing treatment for a condition lower than 587th would not be allocated funding. This was made clear from the explicit nature of the rationing process which clinicians had to follow in order to claim state funds.

One of the most problematic aspects of rules based rationing is the impact a methodology based on aggregate measures, such as the QWB, has on the decision making process when it is applied to individuals. The situation could easily occur where a particular patient needing treatment for a condition not on the funding list would derive greater individual benefit from consumption of that treatment than another individual would from receiving treatment for a condition on the list. However, neatly ranked lists of conditions and treatments are never so tightly drawn as to

preclude some degree of interpretation by medical professionals. As Hall (1994) points out, 'physicians are notorious for their ability to rationalise non-compliance with authority that contravenes their clinical judgement' (Hall 1994: 326). It is more that likely that clinicians will re-categorise their patients as falling within funded disease categories so as to ensure treatment that otherwise would not have been funded. Despite this ability by clinicians to 'work the system' and mitigate against the more unacceptable anomalies, many argue that all 'rules-based' rationing processes are fatally flawed. As Mechanic (1992) asserts:

> [Centralised rule-making] is too distant from the realistic contingencies of disease, the complexity of co-morbidity , and the diversity of personal and family situations, to extend to specific clinical decisions under the conditions of uncertainty that characterise much of medical care. In a large and culturally heterogeneous society it is especially difficult to anticipate varying needs, expectations and tastes of patients and their families (Mechanic 1992: 1721).

Even if, as in Oregon, the priority-setting methodology does include a great deal of public consultation reflecting the diversity of the state's population and value systems, is this the same as saying that a democratic procedure legitimises the moral constraints involved in rationing? It could be argued that Oregon's experiment in explicit rationing, and the limits placed on individual choice by the values of the majority, are a price worth paying to improve health care cover for the large proportion of the population of the state, and the US in general, that are either underinsured or have no insurance at all. The US health care system in general has not shared the NHS's aspirations of equity and comprehensiveness, nor would one expect these collectivist ideals to flourish within a political and economic system which historically put its emphasis on the liberty of the individual. In this light a redistribution of health care resources through explicit rationing is a practical methodology that has a chance of reaching some kind democratic acceptance - not because it is philosophically just or equitable - but that in the American tradition it can be seen to be 'rational'. One of the defining features of the Oregon experiment was the use of a 'rational' technology of priority-setting in the form of the Quality of Well-Being (QWB) scale. The next section explores some of these new technologies of priority-setting and the 'rational' economics discourse in which they are situated.

Rationing and the use of cost-utility analysis

It is the function of all health care systems to maximise the 'health' of their populations given the resources available. If a 'free' market in health care was possible then the price would provide all the information necessary for the consumer to trade off costs against increased welfare that would accrue to the individual through consumption of health services. This is the premise of **cost-benefit analysis** that forms the basis of most economic theory. However, because of market failure in health care this form of analysis is not available. It is simply not possible for the patient, or their advisors, to equate particular states of health and quality of life in monetary terms. Nevertheless, in recent years there has been a proliferation of measures aimed at evaluating health status in non-monetary terms. Three types are discernible. The first group are disease-specific measures, such as Kurtzke's scale for Multiple Sclerosis. These measures have their origins as tools primarily for use by clinicians and tend to embody a narrow medical perspective when measuring quality of life experienced by the patient. Another group of measures are the generic, multi-dimensional instruments, like the Nottingham Health Profile and the SF-36 questionnaire which measure social functioning and mental health as well as physical well being. Because of their generic nature they can be used to gauge health status across a range of conditions. As a consequence, they do have their economic uses. As with disease specific measures, generic instruments can be used to perform **cost-effectiveness analysis** when comparing different treatments for the same condition.

However, despite the value of this procedure in ranking effectiveness of treatments for a particular condition (for example drug therapies instead of an operation), they cannot be used to compare the costs associated with treating *different* conditions. What is needed is a single measure that incorporates effectiveness and quality of life in a single score that can then be costed and compared across conditions. One of the key features of the Oregon health plan was the use of a quality of well-being index (QWB) - although cost comparisons were not used in Oregon. A similar measure that has been widely discussed in the UK is the quality adjusted life year or QALY (see Williams

1985; Gudex 1986; Robinson 1993). The potential for costed QALYs is that it can replicate some of the characteristics of market cost-benefit analysis in the form of **cost-utility analysis**. As such, it appears the ideal instrument for use as part of a rationing and priority-setting debate. However, because it is a proxy measure of the benefits derived from the consumption of health services, its use is problematical, involving many methodological and ethical dilemmas.

The QALY consists of two parts - one supposedly objective, the other highly subjective. The objective part relies on the 'science' of medicine, the technical study of treatment and average expected outcomes in physical terms. This leads to two sets of difficulties. The problem with the objective measure of health outcomes, as highlighted by the discussion of audit in Chapter 4, is that the science of medicine has increasingly been regarded as deficient by independent commentators. As Maynard and Sheldon have pointed out, 'many therapies in every day use in all health care systems have no scientific basis' (Maynard and Sheldon 1995: 7). The additionally difficulty is that even when evidence is available the standard of research is often poor. As the editor of the British Medical Journal (BMJ), Richard Smith, recently remarked, in his opinion only 5% of published articles achieved minimum scientific standards, and 'in most journals it's less than 1 per cent' (Smith 1998). In part, this questioning of the scientific basis of medical practice reflects governmental edicts for 'evidence based medicine' (EBM). At present the standard of scientific research in medicine may be questionable, but at least there is a prospect that more rigorous research is possible. Moreover, EBM raises questions not only of effectiveness but how that effectiveness is measured - in terms of clinical measures or 'patient centred' quality of life. As such, it can seen, along with audit, as an integral part of the rationing/priority-setting debate into effective use of limited resources (and as part of a new articulation of health care governance).

Assuming that the scientific basis of medical practice can be demonstrated, and that is still open to debate, it still leaves open the question of comparing the effects of treatments across a range of conditions. Like the quality of well-being index, the post-treatment outcomes need to be given a quality of life weighting, and in the case of the QALY this done using the Rosser index (see Rosser et al. 1982). The Rosser index

involves producing a matrix of weighting scores derived from measuring the values a sample of the population places on quality of life. The matrix is constructed using two dimensions - disability and distress. The disability categories range from 'no disability' to 'unconscious', the distress categories from 'no distress' to 'severe' distress. The values in the matrix have a range 1 (no disability and no distress), to 0 which equates to death. (Interestingly, as an aside, in the Rosser et al. (1982) study there are two health states with negative scores, 'confined to bed and in severe distress' and 'unconscious', presumably in a permanent vegetative state. This implies a health status 'worse than death'). Using the research evidence of expected post-treatment health status, the weighting can then be employed to produce a quality adjusted life year score for treatment using a pre-determined time scale to judge effectiveness. So if for condition A, treatment X produces 3 QALYs and treatment Y produces 2 QALYs, then it appears treatment X should be recommended. However, what if treatment X is three times more expensive than Y? In these circumstances the cost per QALY of X is twice that of Y, so it follows that Y should be purchased. The logical extension of this analysis is then to compare the cost per QALY for condition A against other conditions. If the marginal cost per QALY for treatment Y is less than for other alternative uses of this money, then Y should be purchased. This inevitably leads to the creation of 'league tables' of marginal cost per QALY rankings (see Maynard 1991). However, there are technical and ethical problems associated with the use of 'league tables' that have to be addressed if they are to be part of an explicit rationing/priority-setting decision making process.

Firstly, QALYs can only be commensurate if they are created within a shared tightly defined methodology. They must cover the same time period, even refer to the same country, they must share the same quality matrix and share a host of other technical details - discounting, cost calculations, baselines etc. (see Mason et al. 1993; Drummond et al. 1993). Thus the calculation of the QALY becomes a highly technical enterprise fraught with problems. Even so the temptation is still to collect QALY studies and arrange them in 'league tables', gloss over their differences, and use these as a basis for decision making. Again, an additional difficulty with aggregate measures is the recurrent problem of moving from the general to the particular, from the abstract to the concrete. If the QALY is to use the best available evidence, it must be calculated

using national, or international data. Therefore, the cost per QALY calculus will be subtly influenced by local factors - differences in local medical expertise, variation of approach within treatment areas, availability of specialist equipment and staffing levels, even variations in local pay rates would alter QALY calculations. However the ability to recalculate QALYs to suit local circumstances is beyond the expertise, available time or resources of local purchasers. QALYs can only be seen as one aspect of the technical exercise of purchasing. In the absence of simple unproblematic yardsticks to judge such rationing decisions, a dialogue of technocrats may evolve - excluding the public from the debate.

Aside from the methodological problems, there are additional difficulties associated with the values incorporated into the initial quality of life weighting index. As one would expect, the subjective measure of 'quality of life' used to weight expected outcomes will include a degree of variation between individuals' assignment of social value to different levels of pain and disability. However, even if the variation is within 'acceptable' statistical limits, including population differences - between professional and lay values for example - the quality of life weighting still remains an aggregate measure. In fact both aspects of the QALY - the objective and the subjective - are aggregates because they reflect collective studies and collective values respectively. Furthermore, as demonstrated in the Oregon example earlier, it is in the nature of aggregate measures to produce paradoxical results when applied to individuals. Two individuals undergoing the same treatment with similar expected outcomes may rate their own post-treatment (and pre-treatment) quality of life completely differently and therefore their individual QALY scores would also be different. However, it simply is not practical to even attempt to compute QALY scores for every individual, and even if one did there is no guarantee that they would be consistent over comparatively short periods of time. So it can be argued that the use in priority decision making of the QALY (or other 'quality of life' measures) emphasises efficiency over equity - furthering the interests of collective average welfare over individual welfare. Additionally, the use of QALYs introduces a bias against those with limited life expectancy who can generate only a limited number of QALYs. Thus the QALY measure actively discriminates against the elderly. This raises another problem, the difficulty of trading off quality of life against life itself. As Harris (1988) states:

> Most people think, and for good as well as prudent reasons, that life saving has priority over life enhancement and that we should first allocate resources to those areas where they are immediately needed to save life; only when this is done should the remainder be allocated to alleviating non-fatal conditions (Harris 1988; quoted in Klein et al. 1996: 33).

Again, we see the 'rescue' principle being re-asserted to obstruct 'rational' decision making. This highlights another problem of using an economics-based counterfactual argument to aid the priority-setting process. As Hardin (1980) asserts, 'professing a petty faith in counterfactual conditionals... such as a 'heroic' answer must be found, implies that there is a 'heroic' and painlessly acceptable answer' (Hardin 1980: 61-62). The basis of the QALY argument is that the QALY is acceptable because it approximates to those counterfactual conditions that would apply *if* a market existed. However, even if one accepts the logic of the argument, it carries no moral weight. Just because something has a low cost per QALY ratio does not mean it is more acceptable that a treatment with a higher ratio. For example, an individual undergoing gender reassignment may experience an enhanced quality of life post-treatment that yields a low cost per QALY ratio, but this does not stop many people from voicing their opinions that this is an inappropriate use of NHS resources. The opposite of this also applies when a QALY analysis is used for therapies which many do not regard as a legitimate 'health' need, IVF treatment is a prime example. For many health care purchasers IVF is a problem area (Redmayne and Klein 1993). Many health authorities do not consider it a health need that merits funding. Yet it is a moot point whether this reflects the opinion of the general public. In the absence of such information, the QALY on its own is not a sufficient basis to make priority decisions. The calculation of QALYs for IVF is itself difficult, spreading the calculation across all the individuals or couples, and taking into consideration the number of expensive cycles of treatment typical needed, the QALY yield might be quite small. But if one factors in the number of QALYs a new life would generate the end result could be quite high. Overall, the use of QALY is complex and fraught with difficulties. In certain circumstances their use may be beneficial as a heuristic device. However, QALYs can never absolve the purchasing authority from making difficult choices about allocating resources to meet

local health needs. The assessment of health needs is fundamental in that it is the basis of priority decision making. The concept of health needs assessment is discussed in the next section.

Assessing Health Needs

One of the defining characteristics of the NHS as a health care system is its command economy structure. Within command economies there is a tendency to confuse the roles of supply and demand. In the economic analysis of market exchange the function of supply and demand remain separate. In many ways the 1990s the NHS quasi-market reforms echo this in the separation of purchasing health care - the demand function - from providing health care - the supply function. However, in reality this demarcation of roles is not as easy to maintain. To illustrate this one can turn to Klein et al., who in evidence to the Health Select Committee (26 May 1994), outline four elements the ideal purchasing model should contain:

1. The purchaser has to develop a currency of evaluation for assessing both existing commitments and new claims on resources: the criteria to be used when deciding on how to determine priorities among competing claims and allocate resources.

2. The purchaser has to draw up an inventory of existing service provision: that is, there has to be a benchmark picture of what the authority's money is currently buying and for whom.

3. The purchaser has to assemble the evidence about unmet needs or frustrated demands: to establish in what respects, and to what extent, existing provision falls short of what should be available to the public.

4. The purchaser has to compare the competing claims on resources according to the criteria already developed in order to determine spending priorities. Crucially, if benefits (however measured) are to be maximised, existing

commitments must be treated exactly like new candidates for spending in this exercise.

The first and fourth points, a call to develop a currency of evaluation and to compare claims on resources, appear tailor-made for the QALY or its equivalent. The second point about benchmarking is relevant for a health authority charged with providing the best possible health care for its population. If this means changing the distribution of resources then it is best to know how these resources are presently arranged. And finally, the third point makes clear that the purchaser must devise a way to describe the demand for health care in the local population. Taking all four points together, it is clear that the role of the purchaser is not simply to respond to demand, but also to construct demand by some means and then manage supply using cost and quality measures so that they roughly match. As with the discussion of the construction of the QALY as a measure of utility, the methodology employed in this process is all-important. Constructing the means of understanding supply and demand, is essentially the same as constructing a discourse in which 'health' becomes meaningful, which in turn constructs individuals subject to that 'health' discourse

Since the introduction of the 1990 NHS and Community Care Act, District Health Authorities have been given the statutory duty of arranging health care for their client populations, with the additional injunction that they should seek to meet local 'health needs'. With the current emphasis on effective use of resources, Health Needs Assessment (HNA)holds forth the promise of bringing into sharper focus the demand element of health care as opposed to the 'supply-led' provision of health care that has hitherto characterised NHS priorities. However, promising as HNA may be in theory, it is the means by which it is attempted that will have a potent effect on whether a balance between supply and demand will be possible. To highlight this, there will be a brief discussion of two contrasting (but not mutually exclusive) methodologies - one based on epidemiology, the other on social research. These two approaches mirror different definitions of 'health need'. On one hand, health need can be defined as the 'ability to benefit' from health care, emphasising a primarily medical model, which in effect links 'health need' to the supply function as well as demand. Yet on the other hand, we have an apparently wide definition of health expressed in the Government's

The Health of the Nation initiatives that includes elements that are not overtly 'medical' concerns such as life-style, diet and exercise, in order to maximise the nation's 'health' (see Bradshaw 1994).

The appeal of epidemiology to any 'rational' investigation of health needs is its appearance as a branch of 'hard' medical science. It deals with demographics and the statistical incidences and prevalence within populations of neatly categorised diseases and illness. Obviously such a relatively straightforward approach has great appeal for any DHA setting priorities for spending within a defined population. For instance, if in the light of an epidemiological study a population exhibits an unusually high occurrence of respiratory problems or heart disease, it would be remiss of any health authority not to take this into account, both in terms of provision of treatment, and within limits, prevention. The problem occurs if 'health' is only perceived within this medical model, when epidemiology shares the same disease categories that produce the definition of health 'need' as 'ability to benefit' from health care. It then follows that if you cannot benefit from existing health care provision then there is no expression of 'need' and therefore, it is not amenable to epidemiological analysis. The concept of need thus becomes circular and reinforcing, need becomes confused with both the supply and demand functions for health care. Therefore the dynamic for change in health provision becomes purely medical and potentially very conservative in nature, with a risk of perpetuating unconscious biases and treating symptoms not causes. Moreover, the health purchasing agency runs the risk of not fulfilling its remit of maximising 'health gain' for its population within the resources allocated.

The assessment of 'health need' does not necessarily have to be defined so precisely. The World Health Organisation defines health more widely as 'a state of physical, mental and social well being, and not only the absence of disease and disability'. This opens up the debate on health needs to include a host of non-medical interests. It also overwhelms the neat categorisations of epidemiology. Health, and therefore health need, becomes more fluid, multidimensional, invites investigation of other non-medical causes of ill-health and ultimately opens up the concept of health for consideration from the perspective of a variety of differing value systems. This is the realm of the social researcher used to confronting value-laden evidence and unconscious biases (see

Williams and Popay 1994). Within this wider definition of health, non-medical factors come to the fore and have the habit of spilling into the areas of responsibility of agencies other than the DHA. This means that legitimate claims of 'health need' will come from areas outside the immediate responsibility of the Health Authority. Thus, a wider definition of 'health needs' implies that one must include any actions or policies that increase the overall levels of 'health' within the population. These may be as diverse as preventative medicine and health promotion, or general government policy, such as increasing the quality of the housing stock, maintaining a clean water supply and promoting a stable labour market, which emphasise measures that fall outside the remit of the health system. This appears to advocate a return to a public health model of health, or 'New Public Health' (NPH), as discussed in Chapter 3 (see Armstrong 1993; Nettleton 1995). The problem for the purchasing agencies is making this wider definition of health meaningful within the restrictions of a formal health care system. However, when the definition of health changes so does the understanding of how individuals fit within new discourse of health care. The consequences for the individual constructed within the 'New Public Health' discourse is explored in the next section.

The construction of the individual in the 'health' discourse

The focus of governmentality analysis is, at its most basic, an investigation of the discursive space that 'renders reality thinkable in such a way that it is amenable to political deliberation' (Rose and Miller 1992: 179). Extending this analysis to health care, one could argue that rationing/priority-setting debate, the use of QALYs, audit, particular forms of health needs assessment and the concept of the New Public Health, are all aspect of a problematisation within a discursive space that makes health care amenable to political action. To be more specific, it is more appropriate to characterise these phenomena as part of a *re*-problematisation of the 'health' discourse, as part of a shift in the articulation of liberal governance from collective forms of welfare to one that emphasises individual rights and responsibilities. By defining health as something more than the absence of illness (as in the WHO definition), agencies charged with the duty to generate 'health', need to make it part of a 'calculus of health' in order to demonstrate effectiveness. An understanding of health in terms of quality of life, as in the New Public Health formula, is one such approach. Therefore, the health agency has

to show that for a given allocation of resources it is trying to maximise the aggregate level of quality of life for its population. One of the consequences of this is that the agency will emphasise preventative strategies as part of health promotion. However, to maximise aggregate 'health', health promotion must focus on individual behaviour. As McQueen (1989) argues, the collective and the individual are linked:

> … because the rhetoric of health promotion and the New Public Health is social, but the actions, the behavioural base, are at the individual level. How else can one explain public health rhetoric which argues that social conditions affect health outcomes and then, in turn, argues that the appropriate solution is to eat better, exercise more, drink less and give up smoking (McQueen 1989: 342; quoted in Nettleton 1995: 237).

An intrinsic characteristic that arises from the definition of population health as being dependent on individual behaviour is that it becomes part of the duties of the responsible citizen not to indulge in those behaviours likely to result in ill-health and thus add to the burden on society through the provision of health care. However, since most of these behaviours are as commonplace as not eating the right food or drinking too much, then the implication is that we are all at risk of adding to aggregate levels of ill-health. Therefore, the health agency, in terms of the NPH discourse, is really in the business of managing health risk. This was a theme explored in Chapter 3, where it was argued that neo-liberal health policy leads to a re-coding of health problems as social and behavioural problems. The individual is encouraged to perform a kind of self-governance, to engage in a form of self-entrepreneurialism of health or 'prudentialism' (O'Malley 1992) and to avoid risky behaviour that places a burden on the rest of society. In effect, the management of health risk is one of the most fundamental forms of governance.

If risk an intrinsic element of the management of health in neo-liberal forms of governance, then it is wholly consistent with the definition of neo-liberals as essentially a reflection of neo-classical economics. The subject of this economics discourse, *homo economicus*, is the same kind of prudential, rational, self-governing individual described above. However, because of the well known problem of market failure in the provision of health care, *homo economicus* is not the subject of the discourse of health

economics. To mimic market conditions and make health amenable to understanding within an economics discourse, a number of proxy indicators have to be created - in the NHS these include the creation of the quasi-market and its constituent technologies, such as audit and evidence based medicine. As mentioned earlier, many of these technologies are based on aggregate calculations. As a consequence, the subject is constructed through the use of statistics as being a collection of risks factors similar to that of the insurance technologies (see Ewald 1991).

The author of these new health technologies is an emergent form of 'expert', the health economist. The function of this form of expertise in neo-liberalism is to allow closer supervision of the health system so as to control its impact on public spending. Neo-liberal forms of health care governance have to put in place methodologies and technologies that generate legitimacy for government intervention in health care and the de-collectivising of the welfare state without paying too high a political price. The health economists provide such a legitimising device in the form of economic rationality. As Ashmore et al. (1989) observe:

> In general, their [health economists'] goal would be to replace *ad hoc* and politically motivated decision-making, as far as possible, with an impersonal means-ends calculus analogy to that of the idealised individual actor which provides their basic model of economic rationality (Ashmore et al. 1989: 36).

This economic model may be the basis of a 'strong programme', where it is posited that economics provides *the* rationale for arranging health care. Or it might be a 'weak programme', in which economic analysis is suggested as a possible source of technical help in decision making (ibid.). Either way, the economic rationale provides a justification for the decision-making process, allowing it to pass the test of 'reasonableness'. If the decisions on priorities are seen to be 'reasonable', ie are based on a rational process, then they may also be said to be defensible in public debate and be less problematic politically. The basis of these assertions is, as noted in Chapter 3, that free market economics is 'capable in principle of addressing the totality of human behaviour, and, consequently, of envisaging a coherent, purely economic method of programming the totality of governmental action' (Gordon 1991: 43).This use of

economic models of behaviour as the basis for explaining all social behaviour can be seen in the work of Gary Becker (1976) and the 'new institutional economics' (NIE) of Oliver Williamson (1975).

One of the most persuasive critiques of this economic paradigm is provided by the work of US sociologist Mark Granovetter and his concept of the embeddedness of economic action in social relations. Granovetter's work is not only a response to the imperialism of economic theory, it also represents a willingness to challenge economics on its own terms, to '[open] up... the academic debate about the economy to include a genuinely social perspective' (Granovetter 1992: 1). He recognises that his programme must be subtle enough to avoid the traps inherent in both disciplines, and broaden the economist's concepts of methodological individualism and economic action, without setting up this new economic sociology as a new form of imperialism. Granovetter's concept of economic activity being conditioned by pre-existing social relationship provides a critique of neo-liberal economics. As Granovetter and Swedberg (1992) argue:

> Economic action is socially situated and cannot be explained by reference to individual motives alone. It is embedded in ongoing networks of personal relationships rather than being carried out by atomized actors. By *network* we mean a regular set of contacts or similar social connections among individuals or groups. An action by a member of a network is *embedded,* because it is expressed in interaction with other people. The network approach helps avoid not only the conceptual trap of atomized actors but also theories that point to technology, the structures of ownership, or culture as the exclusive explanation of economic events (Granovetter and Swedberg 1992: 9).

The additional benefit of discussing Granovetter's work is that it provides a key element missing from governmentality analysis. In Chapter 2 it was argued that Foucault 'paints a picture of a totally normalised society, not because he believes our present society is one, but because he hopes we will find the picture threatening' (Hoy 1986: 14). The problem is that in presenting the different formulas of governance as totalising, even if it is only for heuristic effect, the components of the power/knowledge discourse of governance become reified as 'ideal types', such as 'welfare liberalism' or 'neo-liberalism'. However, what is clear is that one cannot

simply assume that similar forms of governance result in the same forms of social behaviour, institutions or governments nationally or internationally, when tested empirically. Granovetter's concept of extra-discursive networks of social relations introduces a mechanism that allows the inclusion of contingent factors that modify the totalising discourses described in governmentality. The extra-discursive element of network relationships inhabits the 'non-discursive "residue"' (Fox 1997: 44) between non-discursive reality and the limits of the power/knowledge discourse. It can be argued that it is this 'gap' that allows the space for a nuanced account of the changing structures of governance to develop.

The embeddedness of economic action in social relations

Despite sociology's long tradition of investigating the economic aspects of social life it can be argued that it is ideas of economic behaviour that have dominated this century. This is especially so in more recent times with the rise of neo-liberalism. Traditionally, classical economics has postulated that the economic is inextricably linked with the social, that the order of 'the market' is the order of society. Furthermore, it is assumed that individuals, as Adam Smith asserts, have a fundamental 'propensity... to truck, barter and exchange one thing for another' (Smith [1776] 1976:17), that it is natural order to behave as rational beings and further one's own self-interest. The institutions of the state are there to be impartial regulators of civil life and the market, so the only proper government is therefore limited government. There can be no aggregation of interests that puts itself above the interests of the individual without their consent, to do so would damage society. The consequence is that atomised individuals are a prerequisite to perfect competition (Granovetter 1992: 56). This idea of the atomised nature of economic behaviour is central to modern neo-classical economic theory. It conjures up the vision of the informed individual with a stable set of preferences pursuing his or her self-interest in allocating scarce resources to maximise their own individual welfare. This discourse privileges economic relations above non-economic relations. Social relations act as a drag on the efficiency of the economy, in effect social relations have become the epiphenomena of the market. However, this kind of economic theorising also means that much of what is interesting in the social world cannot be articulated and so is sidelined as a set of inconvenient exogenous variables

that are not amenable to rational calculation.

From Granovetter's sociological perspective the elimination of the 'noneconomic' from the simplified, abstract models of economic action in neo-classical theory results in it being too narrowly formulated. To focus on rational action as exclusively that which is considered to be economically rational is to neglect the equally rational pursuit of non-economic goals, such as those concerned with the approval of one's peers, questions of status and concepts of sociability. This strikes at the heart of the concept of economic actions of the atomised individual abstracted from social relations which lie at the centre of neo-classical economics. As Durkheim states, '...members [of society] are linked by ties that extend well beyond the very brief moment when the act of exchange is being accomplished' (Durkheim [1893] 1984:173). They share a history of past relations and probable expectations of future relationships. As Granovetter argues, to perceive the individual atomistically as devoid of social context is to *under*socialize the conception of human action. Yet as Granovetter notes, when economists do include social factors they tend to *over*socialise the concept, creating stylised groups - such as Piore's segmentation of the labour market (Piore 1975) - or stylised 'typical' individuals (Becker 1976), where to know the role the individual plays is to know their behaviour. Rules and norms of authority become internalised and unconscious.

Granovetter's use of embeddedness is thus part of a conscious effort to avoid both the under and oversocialisation of the atomised individual prevalent in economic analysis, and equally as part of governmentality analysis. But equally he is striving to avoid the charge of oversocialisation often levelled at sociology. The embeddedness of economic action in social relations through networks of concrete, personal relationships is a means of introducing flexibility into economic action and avoiding the dangers of functionalism. Additionally, if individuals have pre-existing social relationships then the atomistic relationship of economic exchange no longer is the sole guarantor of trustful behaviour. In effect, networks of social relationship provide an alternative mechanism for reducing opportunistic behaviour. This will be discussed in the next section.

Trust and malfeasance

One of the problems that stems from the concept of the de-contextualised, atomistic individuals of classical and neo-classical economics is what stops them acting opportunistically? The usual formulation to account for the general absence of malfeasance is to point to the market as a generator of normative standards of behaviour. In an oversocialised, Hobbesian sense, these rules and norms are internalised and order and trustworthy behaviour ensues. However as Granovetter points out, new insights into the less-than-perfect market at the micro-level gives ample scope for opportunist behaviour. Therefore, other mechanisms must be formulated to account for it. The advent of new institutional economics (NIE), provides one such account within the framework of the neo-classical model. The re-interpretation of social institutions allows them to be seen as an efficient, evolutionary response of the market to issues of trust and malfeasance. They provide a legalistic arena where implicit or explicit contracts (Okun 1981) or authority structures that act through 'fiat' (Williamson 1975), can regulate and therefore negate opportunist tendencies. This is seen in the NHS reforms of the early 1990s, where trust relationship that formed the basis of welfare liberalism, were re-constructed in market terms, for example through contracts between purchasers and providers, or re-establishing trust with medical professionals through the audit process. However as Granovetter observes, '[t]hese conceptions are undersocialised in that they do not allow for the extent to which concrete personal relations and the obligations inherent in them discourage malfeasance, quite apart from the institutional arrangements' (1992: 60). Furthermore, they are not mechanisms that produce trust, they merely act as a substitute for it. The problem of untrustworthy behaviour does not go away - it is an invitation to find even more ingenious ways to act opportunistically or for professionals to re-assert their autonomy.

Granovetter argues that concrete personal networks of relationships provide a more subtle and convincing approach to trust and malfeasance. Reputations become personal constructs - an aggregation of personal and others' assessment of past experience of trustworthiness. This information is cheap, of good quality and from sources with whom one has ongoing social, as well as economic, expectations of trust and good

faith. For example, contacts between organisations are generally based on prior knowledge of each other. There will be networks of buyers, sellers, purchasers and providers etc. whose relationships will not be based on narrow, atomistic spot-market exchanges but on well-founded expectations of future behaviour. There is no need for the tight complex contractual arrangements - an informal word to smooth things out and a desire to 'keep the lawyers and the accountants out' (Macaulay 1963: 61) may be enough. And as Eccles (1981) suggests in his notion of the 'quasi-firm', informal arrangements can be as an effective means of control as authority by 'fiat' in the hierarchy. Thus there is no need to rely on undersocialised notions of institutional arrangements or generalised reputations. However, Granovetter strives not to fall into the trap of replacing one type of functionalism with another. There are limits to the scope of networks of social relations, as they '... penetrate irregularly and in differing degrees in different sectors of economic life, thus allowing for what we already know: distrust, opportunism, and disorder are by no means absent' (Granovetter 1992: 61-62). Personal expectations of trust can be abused by individuals and groups of individuals with even more disastrous consequences. And there is nothing stopping one network of social relations being in conflict with another. In Hobbes's 'state of nature', conflicts would be limited to one's immediate neighbours; networks allow for conflict on a much grander scale. The implications for classical and neo-classical economic theory are severe. There is no role for the influence of networks of social relations on economic action in standard economic theory. Yet as Games Theory has shown, the better and more certain one's knowledge is of the intentions and motivations of others the more it has an effect on our rational decision making process. One can speculate that even if the initial economic conditions of two situations were identical, but there existed a network of prior relations in one and not in the other, the economic behaviour of those involved in each may be completely different - and be beyond the capacity of classical theory to explain.

The evolution of institutions

In the previous section the role of institutions in maintaining trust and suppressing malfeasance was mentioned, yet there was no discussion of the greatest problem concerning institutions - where do they come from? Classical economics builds

upwards from the microeconomic to the macroeconomic but there is no economic mechanism that can account for their creation. One can put this another way - how can a market comprised of atomised self-seeking individuals with transitory relationships based on exchange, spontaneously create overarching macro-institutions? The response of the economist is either to treat the problem as one more exogenous variable or invoke a vague concept such as 'culture' as a kind of '*deus ex machina*' (Granovetter 1992: 254). In governmentality analysis the evolution of institutions is a direct result of a problematisation that has arisen within a particular formula of governance. The creation of institutions regulated by expertise are part of the solution. New institutional economics provides a similar understanding of institutional evolution. Williamson re-interprets institutions as rational, efficient market responses to certain failures of the market. The mechanism invoked is one in which an evolutionary process selects a particular institutional structure that is the optimally efficient solution to a particular problem. As Andrew Schotter argues, '[e]conomic and social systems evolve the way species do. To ensure their survival and growth, they must solve a whole set of problems that arise as the system evolves. Each problem creates the need for some adaptive features, that is, a social institution... Every evolutionary economic problem requires a social institution to solve it' (Schotter 1981: 1-2).

For Granovetter there is no need for adaptive narratives to account for institutional development. He sees them as being constructed by the interaction of networks of interests 'against the background of constraints given by the previous historical development of society, polity, market, and technology' (1992: 18). Therefore, institutions are a product of the embeddedness of economic actions within social relations. It is argued, 'that institutions are not the kind of objective, "external" realities they seem. Instead they are typically the result of a slow, social creation; a way of doing something "hardens" and "thickens" and finally becomes "the way things are done" (ibid.: 17). Also it is suggested that the development is path-dependent, that is to say chance plays a part early on before it 'thickens' and 'hardens', altering the structure of the institution so that the most 'efficient' solution does not necessarily always succeed. It is in this early stage '...that networks may play a crucial role in the formation of an economic institution; once the development is "locked in", their strategic importance declines' (ibid.: 19). In essence, Granovetter is rejecting

functionalist arguments, particularly those of Williamson, but is also presenting a critique of functionalist arguments inherent in governmentality analysis that derive from the use of 'ideal types'. However, the difference between NIE and governmentality is that NIE is principally an economic discourse, a totalising discourse at that, consequently it is still unclear how macro structures arise even if they are 'rational' solutions. Governmentality, as part of the wider Foucauldian programme, is predicated on seeking to understand the changing nature of discourse and with it the context in which institutions operate. However, governmentality does have a non-discursive space in which resistance can exist, disrupt discourses and lead to change. Therefore, the usefulness to governmentality of the role embeddedness of social relations is in the way it creates ripples in the smooth surface of the power/knowledge discourse. The ripples are the contingent elements that define evolutionary development. In terms of the NHS, they are the background noise of competing networks of interests - political, medical, financial - that interact as the new health discourse in the NHS 'hardens' and 'thickens' into an institution that soon 'becomes the way things are done'.

Conclusion

The two aims of this chapter were, firstly, to outline some of the key concepts in the rationing/priority-setting debate and second, (and more importantly) to place this debate within a governmentality context. The first section of the chapter explored in some detail the conceptualisation of health and health care provision within an overtly economic discourse. This new health discourse re-codifies in predominantly economic terms the problems associated with providing an effective health care system. As a consequence, health care becomes amenable to a rational discourse that seeks to overcome the obstacle of 'market failure'. In particular, it was argued that the changing articulation of governance from welfare liberalism to neo-liberalism led to a re-problematisation of health care in which implicit and explicit forms of priority-setting and rationing became key issues.

The second part of the chapter discussed some of the new technologies of health governance, such as the QALY or the QWB index, which act as proxies for market

conditions and provide a 'calculus of health' in which economic concepts can be expressed. However, one of the consequences of this is that the subject of this health economics discourse is not the same as the one that inhabits the world of classical economics. The use of proxy measures shifts the focus of the economics discourse away from the individual to that of an idealised, statistical construct which can be inserted into a 'rational' calculation of health. The result is that individuals can only enter into the health economics discourse when defined in terms of the statistical calculations of risk. The role of organising health care provision is transformed into the management of 'risky' individuals. The use of quality of life measures leads to the concept of 'health' and health need becoming much more widely defined, as witnessed by the development of the concept of the New Public Health. Therefore, the concept of risk is widened to include practically all aspects of life. To the extent that everyone is included in the 'risk society'.

The discussion of Granovetter's concept of the embeddedness of economic action in social relations plays a dual role in the chapter. The idea of embeddedness is used to critique the totalising nature of economic models of social behaviour which creates the notion of the 'risky' individual. However, additionally, the notion of embeddedness also provides a key element missing from governmentality analysis. The extra-discursive nature of network relations introduces a nuanced account of discourses and their resultant practices explored by governmentality analysis. This is particularly relevant to the analysis of institutional development, such as that of the NHS, outlined in the next chapter.

Part Two of the thesis situates the recent development of the NHS within a governmentality theoretical framework, and presents and analyses empirical evidence describing the role played by health authorities in commissioning health services to meet local health needs. The analysis will examine the influence that new technologies of priority setting have on shaping the 'rationing' debate and the influence of the 'consumer' on health authority commissioning decisions.

Chapter 6

Health governance and the NHS

Introduction

As previous chapters have sought to demonstrate, Foucault's notion of governmentality provides a coherent and practical framework with which to explore changes in the governance of health care. This is especially so if Foucault's ideas are used in combination with the work of others who have widened his analysis to include other areas social investigation (see Rose 1993; Rose and Miller 1992; Osborne 1993, 1997; also see Chapter 3). The purpose of this chapter, and Chapters 7 and 8, is to apply this framework to the governance of the British health care system, in particular to examine the British National Health Service and the part it plays within health governance. The most important function of this chapter is to place the development of the NHS within an historical context that illustrates the changing nature of health care governance in Britain. The relevance of this framework to contemporary policy making will be further explored in Chapters 7 and 8 with the presentation of empirical material.

However, it is clear from the discussion of Foucault's ideas in previous chapters, (particularly in Chapter 2), that historical data have to be treated with caution within governmentality analysis. Whilst it has been stated that the governmentality framework explicitly rejects the deterministic 'grand narrative' in its presentation of historical evidence, this does not mean that the context it provides adds up to nothing more that a simple chronology of events. Governmentality analysis does supply a structure in which to situate historical changes, but does so by pointing out how contingent those changes are on other factors. Therefore, before presenting a governmentality account of the development of the NHS, it is vital to clarify some of the issues that arise from the method of investigation implicit within governmentality analysis.

Narrative, periodisation and process

The two immediate differences between conventional historical accounts of institutional development, and the interpretation placed on the same evidence by governmentality analysis, are both related to Foucault's explicit rejection of historical narratives. The two problematic areas that arise centre on the use of *periodisation* within the governmentality account of the historical evidence and the questioning of the concept of a *process* shaping government policy. In turn these apparent problems can only be understood by reiterating some of the core concepts within governmentality analysis.

The method associated with governmentality analysis is essentially Foucault's concept of genealogy (see Chapter 2). Foucault describes genealogy as a method that seeks to 'identify the accidents, the minute deviations - or conversely, the complete reversal - the errors, the false appraisals, and the faulty calculations that gave birth to those things that continue to exist and have value for us' (Foucault 1984: 81). In effect, Foucault is arguing that there is no direct mapping between the organisational structure a particular institution evolves and the form of governance that dominates that particular society. However, this does not mean that forms of governance do not shape, in the widest sense, the development of institutions. Particular forms of governance represent the boundaries of the rational discursive space that renders reality as amenable to a form of political calculation. Furthermore, as part of governmentality analysis it is argued that institutions develop and wield power over others because they form the locus where key technologies of regulation operate within the overall formula of governance (see Chapter 3). Institutions, as centres of rational calculation and producers of normative standards, are conduits through which particular forms of governance manage and regulate sections of society.

One of the features of institutional control, and governance in general, is the use of 'expertise' as part of the calculus of regulation. In Chapter 4 it was argued that the function of expertise is highly contingent in two ways. Firstly, there is no iron law which dictates which forms of knowledge become forms of expertise. Often expertise emerges from a morass of competing knowledges, for example, in the nineteenth

century the emergence of 'scientific' medicine as opposed to other forms of medical knowledge. Whether a systematic body of knowledge emerges as an expertise is entirely contingent on the formula of governance *and* any number of exogenous factors. Two ostensibly similar forms of governance could, in theory, incorporate different kinds of regulatory expertise depending on the differing historical circumstances that formed the previous formula of governance. One of the consequence of this is that the nature of expertise, and therefore of institutions, is not fixed. If the formula of governance changes, so does the regulatory function of that form of expertise and any institution in which it is incorporated. In extreme circumstances this may mean that some institutions may cease to be relevant within a new formula of governance because the knowledge they utilise no longer has the status of regulatory expertise. The second contingent factor concerning expertise is that the structures which develop as part of the management of the body of expert knowledge are themselves a reflection of wider social factors, such as gender, race and social status. The variation in potency of these factors within different societies will influence which practical bodies of knowledge become forms of expertise, which become socially marginalised, and which are allotted a supporting role in the division of labour controlled by a dominant forms of expertise (see Stacey 1988; Witz 1992; Nettleton 1995).

In the light of these contingencies, it is important not only to explore the documented historical circumstances which characterised the development of the NHS as an institution, but to place this development within the context that takes into account the formula of governance that prevailed at the time. The most important aspect of this scheme is that it obviates the need to present an evolutionary narrative to account for the development of the NHS as an institution. Instead, it highlights the changing nature of the problematisation of rule which gives the NHS meaning as a locus of regulatory technologies. However, in a clear divergence from conventional narrative accounts of institutional and policy formation, governmentality analysis is compelled to emphasise the discontinuity arising from the discrete periodisations associated with the different problematisations of liberal rule and forms of governance. Furthermore, what is particularly relevant to this chapter, is that the dependence on contingent factors within institutional formation means that there is often a discrepancy between the

periodisation associated with changes in problematisations of rule and the periodisation associated with institutional change. It will be argued in this chapter that the changes in the form of liberal governance do not automatically signal immanent changes in the organisation and function of institutions. An institution, such as the NHS, formed as a solution to the problems of delivering health care within one problematisation of rule may be left substantially unaltered in its function until a new set of concepts has evolved within the new problematisation of rule that make it amenable to political calculation.

One of the consequences of this rationale is that it identifies the process of policy making as the key factor in the transition of institutions as functional elements of regulation within the new formula of governance. In many ways this is not a contentious statement as the policy *process* does imply some form of transformation from one state to another. However, where governmentality does deviate from conventional analyses of policy making is in asserting that the sets of categories and concepts that form the basis of political discourse are only meaningful within particular problematisations of rule. This statement has major ramifications for the analysis of policy making. The most important implication is on the notion of a policy process itself. In many ways the notion of shifts in the problematisation of rule within liberal forms of governance is analogous to the Kuhnian concept of paradigms shifts in the natural sciences (Kuhn 1970). The idea that categories and formulations only have meaning within the then dominant paradigm implies that when shifts in the paradigms occur the meaning attributed to these categories and formulations also changes. Stated in these terms it is evident that analysing policy making from a governmentality perspective has the effect of emphasises discontinuity rather than continuity within the policy process to the point where it calls into questions the viability of the very concept of a policy *process*. The result of this argument is that governmentality analysis presents an implicit critique of conventional policy analysis. The kernel of this critique is that the analysis of the power relations between actors within the policy arena, (particularly from a pluralist standpoint or a reaction against pluralism), is in essence a discussion of the problems that arise and are meaningful within a specific formula of governance. Therefore, any form of analysis which seeks to uncover a long-standing policy process would be potentially flawed because it cannot fully take into account the

changing meaning of the categories which form the basis of any policy debate. The further implication of the governmentality viewpoint is that commentators and academics that engage in policy analysis are themselves seen to represent forms of expertise who utilise specific forms of specialist knowledge essential to governance. These groups have the function of developing new categories that aid political calculation and ultimately may generate new problems which may only be resolved within a new formula of governance. For example, in terms of health care governance and the NHS, one group (whose influence was briefly discussed in Chapter 5 and will be again later in this chapter) is that of health economists who represent a relatively new form of expertise which has been particularly influential within the contemporary health policy debate. However, it has to be noted that the assumption in governmentality analysis that it can critique other forms of analysis by appearing to except itself from being implicated in the dominant formula of governance has not gone unchallenged. In Chapter 2 it was acknowledged that Foucault's epistemological position has come under severe criticism. These epistemological problems have not been resolved and are perhaps irresolvable. However, this chapter and the two that follow, attempt to demonstrate that governmentality analysis of the policy process and the formation of the NHS as an institution does result in new insights that were not immediately available to conventional forms of analysis.

The role of population in liberal governance

As mentioned above, this chapter does not seek to present a conventional historical account of the founding of the NHS as an institution. However, the alternative framework employed in the chapter does make use of the common body of evidential material provided by more established accounts, such as Klein (1995), Allsop (1995), and Webster (1998). Indeed the governmentality account of NHS does employ a similar periodisation when dealing with historical evidence. There is a shared pattern of creation followed by consolidation in the 1950s and 1960s and then a period of crisis and fundamental reorganisation starting in the late 70s until contemporary times. However, underlying these changes governmentality analysis suggests there is a more fundamental periodisation at work involving shift in the formula of liberal governance in Britain. Rose (1993) identifies three distinct - 'if not sharply delineated or mutually

exclusive' (ibid.: 285) - problematisations of rule within UK governance which cover three time periods: the early to late nineteenth century; late nineteenth century to the mid-twentieth; and the period leading up to contemporary times. Each of these periods represents a shift in the formula of liberal governance. The first period is associated with the 'classical' liberalism of the 19th and early 20th centuries with its emphasis on *laissez-faire* economics. The second period from the mid-20th century until the early 1970s, sees the beginnings of the welfare state and 'welfare liberalism'. The third period marks the re-emergence, in the 70s, of classical economics in the form of neo-liberalism. The rest of the chapter uses these broad categorisations to gain insight into the contingent factors that gave rise to NHS in 1948, its function as a part of health governance within the welfare state, and finally, how the NHS had to adapt to the new circumstances of a neo-liberal formula of governance.

Although the evidence is shared, the meaning of that evidence is open to a range of interpretations. For example, given that the NHS is a key element of the British welfare state, governmentality analysis searches the historical evidence for its origins as an regulatory institution by looking at earlier forms of liberal governance. In Chapter 2 it was argued that liberalism, as it evolved in the eighteenth century, placed the well-being of the population as the central concept of governance. This contrasts with earlier forms of governance such as described in Macchiavelli's *The Prince*, where the *raison d'état* revolved around the protection of the physical integrity of land or possessions, of which populations form a part. This is not to say that liberalism was the only early form of governance to derive existential meaning from identifying the strength of the state with the well-being of the population rather than the physical integrity of territory. The 'cameralist' or 'police' states in the German speaking territories after the Thirty Years War also shared this preoccupation (see Pasquino 1991). However, unlike liberalism, in the 'police' state the regulation of the population and the regulation of the mercantile economy were fused together, there was no autonomous rationality to economic activity (Gordon 1991). The state guaranteed prosperity for the population through the provision of administrative order. But this order could only come about through the continuous intervention by the state in society in order to generate knowledge about the population. The simple equation for state governance was that knowledge equals order, and order equals prosperity.

By contrast, the form of governance exemplified by liberalism does grant an autonomous existence to the function of the political economy. The state no longer needs to intervene to guarantee order. In this formula, social and economic order is the reflection of a natural order. Within the narrow limits of mercantile capitalism intervention by the state would be largely unnecessary. In this classic form of liberalism, government is relegated to a regulatory role, maintaining the apparatuses of state that guarantee the 'civil society'. However, with the advent of industrial capitalism in the early nineteenth century this restricted role for the state came under increasing pressure as regulation of the labour force, and the population as a whole, became a central factor in the efficient working of the economy. As Foucault argues, the regulation of population (through *bio-power*) was 'an indispensable element in the development of capitalism; the latter would not have been possible without the controlled insertion of bodies into the machinery of population and the adjustment of the phenomena of population into economic processes' (Foucault 1981; in Rabinow 1984: 263). This highlights the central dynamic within the problematisation of rule reflected in liberal forms of government. As Rose states:

> the recurrent dilemma of liberal government [is] the fear of not governing enough versus the fear of governing too much. Liberalism inaugurates a kind of perpetual dissatisfaction with government, a perpetual questioning of whether the desired effects are being produced, of the mistakes of thought and policy that hamper the efficacy of government, the imperative not to govern more but to govern better (Rose 1993: 292).

Within this form of liberal governmentality the state has the duty to regulate the economy to guarantee prosperity. But the question is how much should the state intervene in the 'natural' order of society to fulfil its governmental remit? Conversely, if industrial capitalism is itself the cause of harm to certain sections of society, is it the proper role of government to ameliorate its worst excesses by having an active official role in the regulation of society? This dilemma is apparent when dealing with the governance of health care. The general health of the population is clearly linked with overall levels well-being. Moreover, the general health of the population has a bearing on the productive capacity of the economy. Hence the dilemma. If the conditions

associated with industrial capitalism are injurious to health, and ill-health is damaging the productive capacity of the workforce, then can this dilemma be resolved within the problematisation of rule that informs a particular formula of governance? If it cannot will there be a shift in the formula of governance in an attempt to resolve this dilemma? This is the background to the next section which explores the historical circumstances that led to the founding of the NHS.

The State and the provision of health care

The first problem with searching for the origins of the NHS is where to start. If we begin from the basic premise that the NHS is an institution that has meaning within a liberal form of governance then we must start with early problematisations of liberal rule. The late seventeenth and early nineteenth centuries witnessed the first flowering of liberal forms of governance. However, it is equally apparent that the earliest forms of liberal governance did not reflect the same concern for population health that would be associated with later forms of health care governance. That is not the same as suggesting that there were no forms of organised health care. In the early nineteenth century there were many sources of health care services, ranging from the practitioners of folk medicine to voluntary hospitals, including prestigious institutions dedicated to teaching medicine (see Stacey 1988; Abel-Smith 1964). Yet, even if one takes all these sources together, clearly they did not constitute a health care *system*. Nor was there any pretence that they should. In the early nineteenth century the concept of a systematic form of health governance had not become part of the problematisation of liberal governmentality. However, the pressures of an rapidly expanding and mobile population needed to meet the needs of newly emergent forms of industrialism were putting pressure on even this meagre provision of health care. As Stacey (1988) observes:

> The flood of people to the towns in the eighteenth century, which increased in the nineteenth, dislocated the networks of healers based upon the domestic domain upon which the great majority of the people had relied. Notwithstanding the serious hazards of eighteenth- and nineteenth-century hospitals the common people therefore turned to them for succour in times of illness (Stacey 1988: 62).

With high population density came the real danger of epidemic killer diseases such as cholera, typhoid and tuberculosis. For early nineteenth century policy makers this spectre of illness and 'contagion' only added to the existing perception of danger, of social disorder, and moral and political chaos, that were associated with the influx of working people into newly industrial areas (see Morris 1976). It has been argued that one of the primary reasons for the introduction of the Poor Law of 1834 was to regulate this new population of poor labourers and their families (Dean and Bolton 1980). This is the first real instance of the state, albeit the local state, becoming directly involved in the management of population health. However, this was not management of the population as a whole but a section of the sick-poor who were seen to be 'deserving' of treatment. The 'undeserving' poor, the malingerers and the feckless, were to be dissuaded from taking advantage of the generosity of the state by the harshness of the regime in the workhouse and the workhouse infirmary. In many respects, it could be argued that the Poor Law represents the beginnings of the welfare state (and ultimately the NHS), or at the very least it marked the beginning of the shift in the formula of liberal governance that would see the welfare state as part of the solution to the problem of governance. This assertion is sustainable because of two key factors that the Poor Law represents. Firstly, as already mentioned, it associates the state with the regulation of the population, even if it is only a section of the population. The second important factor is that the Poor Law was based on the use of state-licensed officials, the parish Medical Officer together with doctors, who utilised forms of knowledge that later become forms of expertise.

In the previous section there was a conscious attempt to distinguish between 'expertise' and 'knowledges'. This, in part, is to emphasise the difference within governmentality analysis between bodies of systematic knowledge which have a regulatory function within a formula of governance and those which do not. One of the key features of expertise is that it enjoys a certain degree of state sponsorship. In Chapter 4 it was argued that this is one of the key characteristics of the medical profession and professions in general. The concept of expertise together with the principle of professional autonomy, allows the state to govern 'at arms length'. One of the consequences of maintaining and expanding a expert body of knowledge is that the

concept of population increasingly become part of a nexus of professional calculation. Expertise mediates lived reality so as to make it amenable to analysis, and ultimately amenable to regulation (see Latour 1987). In conceptualising the role of expertise this way, the discussion of public health initiatives in the previous section acquires an added dimension. Early public health legislation had invariably included a medical practitioner, be it part of the Poor Law Act of 1834 or the Public Health Act of 1848. However, it was not until the Medical Act of 1858 that medicine had the power to regulate entry into the profession and legal authority to control the use of medical knowledge. Once this had happened it was perhaps only a matter of time before a monopoly over practise was enforced and all aspects of health intervention would fall within the remit of the profession. Thus, because of the pre-existing involvement in the organisation of UK public health services, medical professionals became historically embedded in the structure of state regulated health care. Often this close association with the provision of state sponsored health care went beyond passive involvement and, in many instances, resulted in influence over the composition of the service itself. This can be seen in the involvement of the medical profession in the discussions leading to the 1911 National Insurance Act. As Day and Klein (1991) note:

> The alterations [in the detail of the Act] were all of a nature which brought the system more into line with the wishes of the profession. The position thus secured by the [British Medical] Association has never been lost - on the contrary, each successive Government has acknowledged the Association as the representative organisation of the whole profession, a gain which itself would justify all the energy and money expended during the struggle (Day and Klein 1991: 5; quoted in Allsop 1995).

The reference to the 1911 National Insurance Act also highlights another dimension of health care governance in the late-nineteenth and early twentieth centuries, that the subject of the developing regulatory discourse was not the population as a whole but specific section within it. Although the 1911 National Insurance Act did represent the first involvement by the state in the provision of health care to individuals (not directly but through 'Approved Societies' and insurance companies) it was never designed to provide medical cover for all the population. The Act was specifically targeted at the working poor, those earning below a certain minimum income. In effect to provide

working men, but not their wives and families, access to general medical services. To some extent the health of poor children had been acknowledged earlier in the Education Acts of 1906 and 1907 which created the school meals and school medical services respectively. And this was reinforced in 1918 by the Maternity and Child Welfare Act. However, taking all these government initiatives together, they cannot be seen as reflecting an altruistic movement towards a comprehensive health care system or reflect the principle of universalism that characterised the ethos behind the founding of the NHS. Arguably the rationale behind the Acts mentioned above, and other state interventions, had more to do with the 'problem' of a potentially volatile and impoverished urban population.

Stacey (1988) observes that Britain in the early twentieth century before the outbreak of the First World War, was characterised by domestic unrest, as 'a number of tensions which had been inherent in the change-over to a factory based economy, sharp divisions between management and labour and tension also in the structuring of the Victorian bourgeois family erupted in those years' (Stacey 1988: 98). Clearly this lends itself to a Marxist analysis, for example that of Navarro 1978, where he interprets the combination of political, commercial and medical interests that formulated the provision of health care in the 1911 National Insurance Act in particular, as reflecting the ideology of dominant class interests obstructing the 'real' interests of the working classes. However, Stacey argues that this class account is incomplete. In her account of the origins of the National Insurance Act she adds an extra dimension of gender which she argues Marxist accounts neglect. Stacey notes that linking health insurance contributions with the working wage systematically discriminates against women who were limited in their opportunities for paid employment. The presumption was that the natural place for women was in the home. The relevance of this for governmentality analysis is that the domestic environment was (and still is) where the bulk of health care took place, utilising the unpaid labour of women in their 'natural' role of wife or mother. In terms of governmentality analysis, this assumption of gender in the provision of health care and the eligibility of individuals to receive state help is also part of the governance of health care in that it reflects the 'mentality' of governance. Governmentality analysis is concerned with uncovering the tacit assumptions that make governance amenable to rational discourse. Embedded within that rational discourse

are those unspoken assumptions about social status, race and gender which place limits on the production of policy.

The origins of the NHS

The discussion so far has presented a series of interventions and initiatives by policy makers that resulted in more and more of the population becoming eligible to receive state regulated health care. The situation by the early twentieth century is presented by Rose and Miller (1992) when they observe that:

> The programmes of social government that proliferated in the nineteenth century involved complex alliances between private and professional agents - philanthropists, charitable organisations, medics, polemicists and others, and the state - formed around problems arising in the multitude of sites with the social body. From the latter half of the nineteenth century onwards, these programmes, and the schemes they gave rise to, were gradually linked up to form the apparatus of the state. These connections were, no doubt, inspired by diverse aims and principles, but they appeared to offer a chance, or impose an obligation, for political authorities to calculate and calibrate social, economic and moral affairs and seek to govern them (Rose and Miller 1992: 191-192).

The question that has to be addressed is how these different programmes 'inspired by diverse aims and principles' came together in 1948 to become the NHS? However, perhaps this is the wrong question to ask, as it presupposes a historical, almost evolutionary, process at work. The more cogent question is what were the circumstances in which the problematisation of governance could shift so as to construct the NHS as a rational solution to the problem of liberal health governance? Providing an answer to this question is central to the governmentality form of analysis. The same question will be posed later with regards to the NHS reform process in the late 1980s and early 1990s. It is argued here that these major changes for the NHS are inextricably linked to shift in the underlying formula of governance.

British health governance between the Wars

No event as momentous as the creation of the NHS happens out-of-the-blue, and the NHS is no exception. As early as 1905 the socialist activists Sidney and Beatrice Webb in a Minority Report attached to the Royal Commission on the Poor Law had argued for a national state-financed health care system. In the years after the First World War there were several reports and Royal Commission findings that advocated the expansion of the National Insurance scheme to cover all the population. For example, in 1920 the Minister of Health's Consultative Council on Medical and Allied Services (the Dawson Report), argued that 'the best means of maintaining health and curing disease should be made available to all citizens' (quoted in Klein 1995: 4). This was joined by other reports that either pointed out the deficiencies of the existing system or called for a national health care system. As Ham (1992) summarises:

> Later reports from the Royal Commission National Health Insurance in 1926, the Sankey Commission on Voluntary Hospitals in 1937, and the British Medical Association (BMA) in 1930 and 1938, all pointed to shortcomings in the existing pattern of services, and made various suggestions for change. These included the need for greater co-ordination of hospitals, and for the extension of health insurance to other groups of the population. The Royal Commission' report also suggested that health service funding might eventually be derived from general taxation instead of being based on the insurance principle (Ham 1992: 13-14).

In his account of the creation of the NHS, Klein (1995) argues that all of these reports amounted to a convergence of opinion that some form of collective provision of health care was the best solution for maintaining public health. Klein describes this consensus as:

> the movement in ideas which made it seem inevitable that some kind of national health service would eventually evolve - dictated, as it were, by the logic of circumstances, rather than by the ideology of politicians or the demands of pressure groups. Basically, this consensus embodied agreement on two linked assumptions. These were that the provision of health care in Britain, as it had grown up over the decades, was both inadequate and irrational (Klein 1995: 2).

In terms of governmentality analysis Klein's overly deterministic account is inadequate. The idea that the NHS was 'inevitable' leaves more questions than it answers. Klein points out that the increasing technical nature of health care and the *ad hoc* arrangement for funding general and hospital services meant that the status quo was unsustainable. He suggests that because of these circumstance, the NHS emerged from a combination of benign paternalism and a technical exercise informed by a kind of administrative rationalism (see Ranadé 1997).

Governmentality analysis would suggest that this rationale is problematic on two counts. The first is the danger with this form of historical rationalisation of creating consensus where none really existed. Taking the creation of the NHS as a logical end-point and then working back through the historical record will tend to privilege those pieces of evidence that seem to fit a pre-determined pattern and minimise the importance of those which do not. The second point to be made is that even if Klein is entirely correct when he identifies a convergence in rhetoric leading up to the creation of the NHS, the question still arises of why did it occur at that particular time and why did it take so long for things to change, remembering that the Dawson Report was produced as early as 1920? What had changed in the meantime to make the NHS a rational solution to the problem of health governance?

A new formula of health governance

One of the strengths of governmentality analysis is that the questions posed at the end of the previous section form an intrinsic part of the analytical framework. For example, using governmentality analysis it becomes apparent that the technical problems which Klein identifies around funding and technology are not the exogenous variables they at first seem. The analysis identifies them as the epiphenomena of a particular form of health governance in which embedded medical expertise was allowed to develop a pattern of health care provision that reflected the hierarchical structures within that profession. As mentioned earlier, Klein observed that the pre-NHS provision of health care services was 'both inadequate and irrational'. The gulf between the élite teaching hospitals and the local infirmaries, once part of the Poor Law system, was immense. Not only in terms of the quality of care on offer but in the geographical distribution of

services. Clearly there was much scope for reform, but how did the NHS become the preferred solution? It could be argued that in this respect the notion of a developing consensus is slightly misleading. There were unquestionably consistent calls for reform but it is equally apparent that not all of the reformers had the goal of creating a health care system that was collective, comprehensive and state-funded, covering the whole population. Many of the calls for change were based on rationales that were mutually antagonistic. For example, while the BMA advocated changes based on the extension of insurance coverage to include almost all of the population, at the same time, it vehemently opposed state funding. This was perceived as a threat to both professional autonomy and to income derived from private practice. Clearly, it is not enough to just list the ideas for reform and expect them to form a coherent whole. The coherence comes from understanding how these articulations of a new form of health care provision reflect a change in the problematisation of rule that makes a reform process meaningful.

The end of classical liberal governance

The political and economic context that gave rise to the articulations of reform have been alluded to earlier in previous sections of the chapter. The social unrest at the beginning of the century, described earlier by Stacey, gave way to the horrors of the First World War. In economic terms the war was followed by a period of economic expansion. However, this proved to be short lived. The General Strike of 1926 saw unparalleled industrial strife which was later overshadowed by the looming spectre of mass unemployment in the 1930s. The factors that were at the root of this of this economic and social unrest have been debated endlessly, but one of the key components was undoubtedly the strict adherence to classical economic policies by successive governments in the 1920s and 1930s. The classical economic response to economic upheaval was to tighten control of monetary policy and maintain low public spending. However, the economic orthodoxies of the nineteenth century no longer seemed to fit the post-war circumstances in which Britain found itself. The return to the gold standard in 1925 until 1931 (when economic pressure forced a humiliating retreat), was a vain attempt to retain Britain's imperial status as a leading reserve

currency. The downturn in global markets left governments with little choice but to tighten monetary policy and protect their own markets. This had the inevitable effect of exacerbating unemployment and further reducing economic growth.

This was the context in which calls for health reform were taking place. Moreover, it also provides the rationale for why early calls for reform had only a limited impact. The inescapable problem is that state health care systems necessarily increase public spending. As Allsop (1995) states:

> Following the Royal Commission on National Health Insurance in 1926, one of the stumbling blocks to the assumptions of state responsibility had been the fear of the high level of public expenditure to which the central government would become committed (Allsop 1995: 25).

Such an open-ended commitment would be anathema to policy makers basing their calculations on classical economic theory. The inter-war years saw public spending running at about 25-27% of GDP, much higher that the 10-12% average of the two decades before the war, therefore the pressure was to cut public spending not to increase it. This inability to articulate a reform process within the prevailing economic paradigm is the key to understanding why it took so long for radical change to be initiated. A comprehensive universal health care system was incompatible with classical economic theory. Therefore, a reform process could only become meaningful within a new problematisation of liberal governance and a new economic paradigm. Such an alternative paradigm was already in existence in the form of Keynesian economic theory. Keynes's theory, developed in such works as *A Treatise on Money* (1930) and *The General Theory of Employment, Interest and Money* (1936), presented a re-articulation of how capitalist economies function. At its centre was the radical notion that economic systems had no automatic tendency to seek equilibrium and full employment. The logic of this argument meant that it was the duty of the government to intervene in the economy to influence demand as well as supply. Higher levels of public spending were therefore no longer anathema but positively encouraged. Furthermore, it provided a rationale for governments to engage in new forms of social policy to counter the more egregious inequalities that arise in the distribution of

economic resource within capitalist economies. Clearly the distribution of health resources also falls within this remit.

By the late 1930s it would appear that all the factors were in place to produce a new national health system. The ground had already been prepared by the calls for reform from sources inside the policy making community which reflected a new articulation of liberal capitalism in the form of Keynesian economic theory. What is more, the orthodoxies of classical economics and the formulas of governance which it sustained, had demonstrably failed to meet the new challenge of mass unemployment and economic depression. However, despite all these elements coming together at the same time it needed the catalyst of another World War to break the political and economic logjam. The experience of mass unemployment giving way to mass mobilisation under a war-time command economy increased optimism that peacetime Keynesian economics would succeed where the previous form of governance had failed.

In this respect, the Beveridge Report of 1942 can be represented as the clearest and most influential articulation of a new form of liberal governance based on the virtues of solidarity and collective responsibility that would finally overcome the 'five giants' that had plagued pre-war Britain - Want, Disease, Ignorance, Squalor and Idleness. And as part of the measures to tackle the ills of the past, new institution had to be created, the most important being a National Health Service that would be free at the point of delivery and cover the whole population. Plainly, this was a radical departure from the pre-war organisation of government-sponsored health services which concentrated on specific groups within the population, such as the working poor and their families. The case was made earlier that the nature of these earlier health services had an overt regulatory element aimed at managing the potential threat from a volatile section of the populace. In contrast, the new form of welfarism outlined by Beveridge was based on a form of collective social insurance. This shift in the subject of health governance is one of the key aspects of governmentality analysis. The important point which must be reiterated is that when the discourse of health governance changes so do the subjects of that regulated and disciplined by that discourse. To illustrate this point, Rose (1993) observes that health governance within the new welfare liberal problematisation of rule employed its own kind of regulatory discipline:

> Social insurance is an inclusive technology of government... It incarnates social solidarity, collectivising the management of the individual and collective dangers posed by the economic riskiness of a capricious system of wage labour, and the corporeal riskiness of a body subject to sickness and injury, under the stewardship of a 'social' state. And it enjoins solidarity in that the security of the individual across the vicissitudes of a life history is guaranteed by a mechanism which personifies what citizens share by virtue of their common sociality. Social insurance thus establishes new connection and associations between 'public' norms and procedures and the fate of individuals in their 'private' economic and personal conduct (Rose 1993: 293).

This new formula of welfare liberalism establishes a new discourse of governance, creating a bounded rational space in which lived reality becomes open to political deliberation. However, as argued in Chapters 3 and 5, the discursive space of governance may appear to be totalising (indeed needs to appear as totalising in order to function), but in reality there is a limit to what the discourse can describe. Because of the existence of a non-discursive 'residue' (see Fox 1997), it is not possible to predict how the institutions of governance develop their internal structures. Ham (1992), working within a different theoretical framework, captures some of the essence of this problem when he states that:

> the administrative structure of the NHS which came into being in 1948 was the product of the bargaining and negotiation which had taken place in the policy community in the proceeding years. It was therefore a representation of what was possible rather that what might have been desirable (Ham 1992: 15-16).

It is in these circumstances that the ideas of Granovetter (1985;1992) discussed in the previous chapter, come to the fore. He describes the process of construction of institutions as the 'mobilisation of resources through social networks, conducted... against the background of constraints given by the previous historical development of society, polity, market, and technology' (Granovetter and Swedberg 1992: 18). This process can be seen exemplified in the creation of the institution of the NHS. The production of the White Paper *A National Health Service* in 1944 created an arena where the resources of the medical profession, politicians and civil servants could be

mobilised through network relationships to construct some sort of compromise. The main stumbling block was the vexed question of professional autonomy within a state funded system. Many of the reforms included in the White Paper provoked vehement hostility from a medical profession who perceived the new institution as a treat to income and professional status. Although the political manoeuvring that went on to persuade doctors to sign up to the new system was in many ways an astute piece of negotiation, a subtle combination of brinkmanship with a policy of 'divide and conquer', the final arrangements for doctors were highly favourable to the profession. Hospital doctors would have significant control over their conditions of employment (which included self-regulated merit awards), consultants could still continue to see private patients and there would be special status for teaching hospitals. In the much quoted words of Aneurin Bevan he had gained support for his proposals by 'stuffing their mouths with gold' (see Allsop 1995: 27). The concessions to general practitioners were equally as significant, perhaps in the long run even more so. GPs were able to maintain their status as independent contractors and receive a guaranteed income through a capitation formula.

Within governmentality analysis the generosity of the compromises offered to the medical profession is indicative of their central importance in the governance of health care as part of a regulatory form of expertise. In Chapter 4, it was argued that that the more a form of expertise is associated with the functioning of the formal state, ie within an institution such as the NHS which is state funded and state owned, then the more autonomy has to be given to those who utilise that expertise in order for it to function. Formulas of liberal governance, by their nature, distinguish between those domains which are the appropriate arena of formal political activity and those domains which are private, inhabited by autonomous self-regulating individuals and their families. Within forms of welfare liberalism this private/non-political domain is regulated through the use of expertise as a 'neutral' body of scientific knowledge (see Osborne 1997). Therefore, the formal state cannot be seen to directly regulating the private/non-political domain without compromising the use of a particular form of expertise as a regulatory technology. However, there are many problematic aspects to this arrangement.

To restate the position, governmentality analysis maintains that the NHS can be viewed as one 'solution' to the problem of providing health care within the confines of a welfare liberal form of government discourse. However, it is a 'solution' that only creates a new set of problems in the functioning of health governance. One of the greatest problems is that the prominence of autonomous of expertise in the delivery of health care allows for only limited managerial control over the actions of those who utilise that expertise. Autonomous professions tend to develop 'enclosed' structures that make it difficult for those outside the profession to challenge the decisions made by experts. The second problem is that as institutions are formed, or as Granovetter describes, as they 'harden' and 'thicken' and finally becomes 'the way things are done' (Granovetter and Swedberg 1992: 17), there is a tendency for the closed nature of profession structures to define the ethos of the institution. Moreover, network relationships that were so important in shaping the compromises that led up to the founding of the institution become one of the few sources of governmental control. However, this mechanism also works in reverse so that professional interests can influence policy making at the highest level.

Taken together, it is clear that government cannot simply impose its will on institutions defined in terms of professional relationships. Therefore, the irony is that institutions of welfarism that depend on expertise, such as the NHS, cannot be controlled from the centre even though they are the products of an economic paradigm that allows for direct government intervention. Therefore, the NHS 'solution' only gives rise to a new set of tensions between central government and medical expertise over bureaucratic control over the health care system. This problem of control is highlighted by Rose and Miller (1992) who argue that:

> [W]elfare was not a coherent mechanism that would enable the unfolding of a central plan. The networks were assembled from diverse and often antagonistic components, from the warring Whitehall Departments to peripheral and *ad hoc* agencies. This was no 'state apparatus', but a composition of fragile and mobile relationships and dependencies making diverse attempts to link the aspirations of authorities with the lives of individuals. Assembling and maintaining such networks entailed struggles, alliances and competitions between

> different groups for resources, recognition and power. The problem posed for the next thirty years, for those aspiring to form a 'centre' from which the welfare apparatus could be governed, was one of regulating those who claimed discretionary power because of their professional or bureaucratic power (Rose and Miller 1992: 193).

This struggle for bureaucratic control has been central to many of the disputes that have plagued the NHS since its inception as an institution of welfare liberal governance. The management structures that were put in place by the 1946 Health Services Act offered little in the way of strategic central control mechanism. Management was fractured rather that centralised. There were 'Executive Councils' that supervised GPs and other primary care practitioners such as dentists, pharmacists and opticians. Local Authorities still had responsibility for a range of services including maternity and child welfare, health visitors and vaccination and immunisation services. On the hospital side several bodies were created to oversee the running of various aspects of the service. For example, there were 'Regional Health Boards' (14 in all), with responsibility for managing the bulk of hospital services through 'Hospital Management Committees'. The exceptions were the teaching hospitals which were administered by boards of governors. Although, these new structures were more streamlined than the collection of disparate organisations that governed pre-NHS health care, at their heart lay the same dilemma that had troubled earlier forms of management. The problem was that while clinicians were free to make the decisions that ultimately determined the allocation of resources they themselves were not responsible for managing those resources. In this respect the new management structures offered only weak oversight. Moreover, because of the newness of the service many of the parameters of managerial responsibility had yet to be worked out. As Bevan observed in 1945 of the new management organisations, 'admittedly this is a field in which there is room for development in the technique of government, but the problems that will arise should not be incapable of solution' (Memorandum by the Minister of Health 1945; quoted in Klein 1995: 18).

Two points can be made with reference to the limits of early NHS management. The first is that despite many achievements in rationalising hospital services, such as the better use made of infectious disease hospitals and the amalgamation of local authority

and voluntary hospitals (see Ham 1992), very little had changed in the distribution of health care resources from that inherited from the pre-NHS service. As Allsop (1995) points out:

> [t]here was almost no capital investment in the new hospitals or major rebuilding. So the marked inequalities in the distribution of hospitals and beds which had been a feature of the pre-war service remained. Forty-five per cent of the hospitals had in fact been built before 1891 and were deteriorating rapidly (Allsop 1995: 40).

It was not until the Hospital Plan initiative in 1962 that large amounts of resources were committed to the problem of the uneven distribution of hospital services throughout the country. In terms of the distribution of financial resource for health care services, this did not come until the Resource Allocation Working Party (RAWP) was set up in 1976. The aim of the RAWP policy was to produce a funding formula that would allow, over time, an equitable distribution of resources between regions. The funding formula has been revised several times since, both in response to methodological criticisms and to 'fine tune' the formula and make it more sensitive to local health needs (see Sheldon and Carr-Hill 1992; Peacock 1995). The current amended formula was introduced in 1995 in time for the resource allocation for 1995/6.

The second point to be made about limited managerial control over how resource decisions are made within the health system is that it leaves politicians the difficult problem of deciding the appropriate level of global funding. The early history of the NHS is characterised by a concern that health care costs were getting out of control. The notion in the Beveridge Report that demands on health care would be self-limiting as the population became healthier were providing to be illusory. For example the expenditure on the NHS in 1952-3 was £383 million, a great deal more than the £170 million anticipated by Beveridge (Watkin 1978). Political pressures began to build up. In 1951 Bevan resigned from the cabinet in protest at charges for optical services and dental work that had been imposed to limit spending on the NHS to £400 million (see Klein 1995: 31). The Guillebaud Committee, set up in 1952 to inquire into the cost of the NHS, was more sanguine about rapid increases in the health care budget, pointing

out that much of the increase was due to increases in general prices. Indeed, in 1951 to 1955 the NHS budget experienced real growth of only 1.1%, and in the next five years by 2.1%. It was only in the 1960s that growth reached the 3% level and this in part was due to the building of the much needed new hospitals as part of the 1962 Hospital Plan. However, the feeling that NHS spending could easily get out of control was not assuaged by statistics. For the politicians who were (and are) held to account for the services the setting of health care budgets would always remain a problem. As Enoch Powell observed during his tenure as Minister of Health, it had become:

> a positive ethical duty for (providers) to besiege and bombard the government and force or shame them into providing more money… and more money again (Powell 1966; quoted in Ranade 1997: 2).

With no mechanism in place to act as a buffer between the constant demand for more and more resources from clinicians and calls to limit public spending from the Treasury, any public perception that the health service is not meeting the health needs of the population is quickly translated into the rhetoric of 'crisis'. Therefore, the management of 'crisis', nationally and locally, itself becomes part of the governance of the health care system.

New forms of health care management

The latter comments again illustrate one of the key aspects of governmentality analysis - that tension between autonomous expertise and bureaucratic control is characteristic of liberal forms of governance. As noted earlier, this is especially true of the NHS where medical expertise was embedded in its institutional structure from the outset. Therefore, governmentality analysis suggests that the problem of control over the NHS is indissoluble linked to the relationship between the centre and autonomous expertise. However, as stated in Chapter 4, the centre/expertise relationship does not imply a form of 'dualism'. It has to be reaffirmed that in governmentality analysis the role of the state and the function of autonomous expertise are basically two aspects of the same form of governance. Both are part of a regulatory process within a particular articulation of liberal rule. However, the *nature* of this relationship between these two

forms of regulation will be defined in terms of the dominant form of governance. When there is a shift in the problematisation of rule then there is an associated shift in the regulatory context in which expertise operates and its bureaucratic management. In the light of this, the following section of the chapter presents the governmentality argument that the problems in management of the NHS at any one time are manifestations of the fundamental centre/expertise relationship within the governance of health care. The initial discussion will focus on major managerial initiatives in the 1960 and 1970s that characterised the relationship between health service bureaucracy and medical professionals.

In the 1960s, as the health care provision continued to expand in size and complexity, new concerns emerged about the role of management in the NHS. Klein (1995) attributes this emphasis on new administrative technologies to the possibilities that were opening up due to economic growth. As Klein argues:

> Consensus in the era of non-growth had meant making the best of the *status quo*. Consensus in an era of growth meant an opportunity to develop new policy tools and organisational formulas; to let experts loose on the problems that had been put into cold storage during the lean years (Klein 1995: 57).

Whether the use of consensus is appropriate way of characterising the relationship between the various element within the health services - medical, political and bureaucratic - is a moot point. The identification of economic growth as the impetus for a new kind of administrative rationale for the NHS has an intuitive appeal. However, in terms of the governmentality framework this form of explanation is seen to be deficient in that it fails to appreciate the limits of management as articulated within the governance of health care. It was noted in the previous section that the relationship between medical expertise and bureaucratic control often manifested itself in terms of disputes about global budgets. In many ways the management initiatives of the 1960s and 1970s were a response from the centre to limit the possibility of these conflicts escalating into 'crisis' proportions and causing political damage. However, what governmentality analysis highlights is that despite the adoption of new and sophisticated administrative frameworks the fundamental relationship between the

centre and medical expertise remained unchanged. The new administrative rationale provides no mechanisms for control over the decisions of individual medical professions which collectively determine resource allocation.

To illustrate this point there will be a brief exploration of two notable examples of this new administrative rationale in action. The two examples are the Salmon Committee on the staffing structure for senior nurses in 1966 and the so-called 'Cogwheel' Reports from 1967 onwards, directed at generating a sensitivity to managerial issues within the medical profession. Each in their way demonstrate different aspects of managerialism when applied to the health service and the relationship between health service administration and the diverse groups within the NHS that utilise medical knowledge. The key difference between these two initiatives is the nature of the relationship between the two groups that were the focus of these new managerial concerns. Whilst both nursing and clinicians share the same body of scientific medical knowledge only one of them is thought of as possessing all the attributes of an autonomous profession body employing regulatory expertise. This was reflected in the manner in which the Salmon Committee and the Cogwheel Working Party were constituted and their conclusions operationalised.

For example, the Salmon Committee was chaired by a leading businessman, Brian Salmon from the food distributors Lyons, not by senior a health service nursing administrator. In contrast, the Cogwheel Working Parties were designed from the outset to have a significant input from medical professionals. This difference in structure was reflected in report findings. The Salmon Committee report recommended that there should be a division between nurse managers and nurse practitioners in order to bring about more effective managerial control over the nursing function. The interesting point is that health service management felt it could impose new administrative structures on increasingly unionised nursing staff without having to incorporate them into the decision making process that devised those changes. On the other hand, the Cogwheel Report limited itself to promoting a 'managerial consciousness in the medical profession' not the imposition of a managerial view (Allsop 1995: 45). As the first Cogwheel Report stated:

The hospital sector is the most complex, sophisticated and costly sector of the medical care services; problems of management proliferate in an organisation with many branches, many functions and many specialties; we believe that many clinicians fail to appreciate fully the importance of their role in management problems (Ministry of Health 1967; quoted in Allsop 1995: 45).

The tone of the report reflects the power of the medical profession within the NHS to circumscribe managerial influence over areas traditionally within the remit of professional responsibility. Administrators could only ask clinicians to 'appreciate' the problems of management. They was no question of administrators imposing a new management structures or redefining the division of health care in which medical professional were situated.

Although the Cogwheel Report and the Salmon Report represent only two of the numerous management initiatives in the 1960s and 1970s, they illustrate the problems for administrators seeking control of all aspects of health service activity. When faced with a autonomous form of medical expertise there appeared to be no articulation of management within the welfare liberal form of health governance to legitimately challenge clinical decisions. As Klein (1995) observes of the Cogwheel process:

> If all consultants became aware of the effects of their individual decisions on the total use of resources, it was argued, they would themselves have an incentive to apply pressure on colleagues who use their beds wastefully: it would make it clear that one consultant's extravagance was another consultant's loss (Klein 1995: 77).

The reported marginal impact of the Cogwheel initiative (Watkin 1978) seems to have only exacerbated the problem for administrators of controlling resources within the health care system. The existence of professional expertise places limits on the legitimacy of managerial control over the (clinical) decisions making process. It is the collective impact of these professional decisions which ultimately determines the allocation of resources. Therefore, in these circumstances, efficiency initiatives can only be furthered by health service managers by devising optimal administrative structures that support and operationalise clinical decisions. In economic terms the

goal is productive efficiency - maximising activity within the constraints of the global budget.

This search for productive efficiency and more efficient forms of organisation can be seen as the defining rationale behind the major NHS reorganisation of 1974. As Klein (1995) notes, the original organisational structure of the NHS with its separate set of administrative structures for hospitals, general practitioners and services provided by local authorities reflected 'political expediency, not administrative logic' (Klein 1995: 82). The reorganisation sought to unify health service administration by creating Regional Health Authorities (RHAs). Within each region there were a number of Area Health Authorities (AHA), coterminous with local authorities, and with planning and management responsibilities. Each AHA had a Family Practitioner Committee (FPC) to administer the contracts of GPs and other primary care practitioners such as dentist, pharmacists and opticians. Beneath this level of administration were the District Management Teams (DMTs), and in a concession to the prevailing concept of consumerism, each district had a Community Health Council (CHC) to represent patient interests (the role of CHCs is discussed in Chapter 8). The reorganisation had three main aims (see Ham 1992): to unify health services (with the exception of GPs) under the control of one authority; to co-ordinate activity with local authorities; and to introduce better management of the type initiated by the Salmon Report and the Cogwheel programme.

However, despite all best intentions the reorganisation was dubbed a failure. As Allsop (1995) observes:

> The 1974 reorganisation of the NHS had been an ambitious attempt to increase efficiency, priority setting and democracy in the NHS. However, the effect of the reorganisation on those working in the NHS was traumatic and the years following were associated with industrial disputes, public dissatisfaction and loss of financial control. The planning and management systems were soon seen to have failed. The response of the government was to set up a Royal Commission (Allsop 1995: 55).

In many ways the 1974 reorganisation was a victim of its own ambition. For example, the administrative logic of coterminous boundaries between AHAs and local authorities was seductive but in practice this arrangement was fraught with difficulties. However, governmentality analysis would point to a more fundamental reason why the reorganisation was perceived to be unable to meet the goals it set itself of improved 'efficiency, priority setting and democracy'. This was because the relationship between the centre and professional medical expertise had not been reorganised and nor could it within the particular form welfare liberal health governance in which the NHS operated. Therefore, no new articulation of management responsibility evolved that could challenge entrenched medical power. Moreover, this was as equally true of the initial response of the incoming Conservative government 1979. Its White Paper *Patients First* proposed a new reorganisation, implemented in 1982, which replaced AHAs with smaller District Health Authorities more sensitive to the health needs of the local population. (The CHCs surviving relatively unscathed). This reorganisation corrected some of the administrative and organisational difficulties that were a direct result of the 1974 reorganisation but again it left the relationship with the medical profession and the centre substantially unaltered.

The beginning of a new form of health governance

As stated earlier, it is not the intention of this chapter to present a conventional historical narrative about the institutional development of the NHS. The primary aim of the chapter was to highlight the value of using a governmentality framework to analyse the role the NHS plays within a particular form of liberal health governance. Nevertheless, it is apparent that the periodisation so far employed within governmentality analysis is not fundamentally different from more conventional accounts of the development of the NHS - even if the basic dynamics of change do differ radically. The sequence of creation, consolidation and crisis is shared with many histories of the NHS, such as Klein (1995), Allsop (1995), and Webster (1998). However, when it comes to chronicling the period of radical change for the NHS in the 1980s and 1990s there is a divergence between conventional accounts and governmentality analysis. The problematic period begins with the arrival of the Thatcher government in 1979 and the identification of this event as a watershed in the

political, social and economic life of Britain. Clearly this was the beginning of a major restructuring of the political landscape. However, governmentality analysis makes the key distinction between changes in the underlying problematisation of liberal rule and changes in the governance of health care. In other words, the Thatcher government may signify a fundamental shift within liberal governance from welfare liberalism to neo-liberalism, but this does not imply that there will be a simultaneous shift within all areas of governance, in particular health care governance and its institutions. It will be argued that changes in the governance of health care that reflect the shift within liberal rule could only take place once a new conceptualisation of the regulatory role of health care within neo-liberalism had evolved. Moreover, this shift is signalled by a new relationship with medical expertise and the creation of new set of subjects for the health discourse.

Previous chapters have outlined the radical nature of the Thatcher and Major governments, so in this section there will be only a brief description of the changes that took place in the NHS under these regimes. The most important function of this section is to draw parallels with the situation in the 1930s and the calls for reforms to the health system described earlier in the chapter. The main parallel is the sense of failure that preceded both these times of radical change. In the 1930s it was the failure of classical economics, in the 1970s it was the failure of Keynesian demand management. The Thatcher governments were unashamedly neo-liberal in character, privileging 'the market' as the dominant aspect of the political economy. In the 1980s the policy of privatisation and encouragement for citizens to became part of a 'share owning democracy' were the *leitmotivs* of government policy. However, when it came to the NHS the government was more cautious. As Mohan (1995) observes:

> [The White Paper] *Patients First* (DHSS 1979) did not recommend any departure from the then system of consensus management; nor did the Royal Commission. However, an implicit goal of the 1982 reorganisation was an attack on the 'unnecessary proliferation' of administrative posts after the 1974 reorganisation, while the 1982 reorganisation was also accompanied by strict management cost limits for health authorities. It was not until 1983 and publication of the Griffiths Report that the question of management appeared on the political agenda (Mohan 1995: 59).

The Griffiths Report of 1983 was indeed a radical document in its call for more efficient and effective forms of management. This is summed up in the oft-quoted comment by Griffiths that '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' (Griffiths 1983: 12). The Griffiths Report advocated the idea of a 'general management' process to stimulate management and to provide leadership and responsibility. One of the other key recommendations was that clinicians should be encouraged to become part of the decision-making about providing services, in part as recognition that clinicians were the 'natural managers' because of their closeness to the actual management of patient care (ibid.: 19). To further this aim concepts such as 'resource management' and 'management budgeting' were devised as a means of involving clinicians in management decision making. The success, or lack of success, of these Griffiths related initiatives have been thoroughly explored by other commentators (see Cox 1991; Flynn 1992; Harrison et al. 1992; Harrison and Pollitt 1994). However, there are two things which have to be addressed when discussing the Griffiths Report. The first is that the Report does represent something of a harbinger of the changes that were yet to come. The Report reflects a model of management derived from the harsh environment of the commercial marketplace. It is a model based not on encouraging consensus but of providing strong leadership and clear lines of authority. This leads to the second point to be made which was also raised in Chapter 4, that despite its radicalism, the Griffiths report is in much the same tradition as the Cogwheel Reports of the 1960s and 1970s. The call for the incorporation of clinicians into management structures does not represent a re-articulation of the problem of health governance. The relationship between the medical profession, as practitioners of a form of regulatory expertise, and the state remains the same as it had done since the founding of the NHS in 1948. As such, the Griffiths Report does not reflect a new form of (neo-liberal) health governance.

The obvious problem this creates for governmentality analysis is in providing a rationale for the apparent difference between the periodisation identified with the shift in the fundamental problematisation of rule, and the subsequent shift from a welfare liberal to neo-liberalism form of health governance. In the mid-1940s there was a clear

link between the shift from classical liberalism to welfare liberalism and the creation of the NHS and the welfare state. However, it is equally apparent that the analogous shift in liberalism and the rise of neo-liberal economics in the 1970s and 1980s was not immediately accompanied by a radical restructuring of the NHS even though other parts of the welfare system had been subject to fundamental change. It was not until the late 1980s that the major reform process attempted to change the NHS into an institution reflecting neo-liberal values. The obvious difference between 1948 and the 1980s was the absence of the crystallising factor of a major world war. The other difference was that by the 1980s the NHS had become firmly embedded in the social and political fabric of the country and no coherent articulation of neo-liberal health governance had evolved. Therefore, for the Conservative governments of the 1980s and 1990s, the management of the NHS was never going to be less than highly political. The fear that the service might be privatised prompted frequent assurances that the NHS was 'safe in their hands'. Even so, this did not protect the government from the political impact of a series of 'crises' in NHS in the 1980s and from the perception that the service was in turmoil as a direct result of Conservative stewardship.

In other areas of government activity the neo-liberal rhetoric of the market and consumer empowerment had resulted in a radical reduction in the involvement of the state in the provision of services. Clearly one of the rationales behind this process of de-coupling the state from the various aspects of the political economy was the hope that this would lead to a de-politicisation of administration (see Offe 1985). With the 'crises' in the NHS becoming increasingly damaging to the government's political standing, and with full-scale privatisation not a viable option, other means of managing the Service had to be devised. In many respects conventional accounts provide an invaluable insight into the key groupings and personalities that influenced policy formation in health care. However, from a governmentality perspective, what is missing from these accounts is an understanding of the problematisation of health governance which government policy seeks to address. In an earlier section of the chapter is was argued that even in the mid-1980s no new articulation of health governance had evolved, especially in terms of the re-articulating relationship between formal state and autonomous medical expertise. However, in the late 1970s and early

1980s a new discourse of health economics was emerging and with it a different form of expertise that could be seen as a basis of a new form of health governance more in-keeping with a neo-liberal economic paradigm.

The importance of health economists to the policy process cannot be overestimated. It is perhaps no coincidence that the transition from welfare liberalism to neo-liberalism that begin in the 1970s was accompanied by a renewed interest in the economics of health care. Indeed, many commentators have remarked on the remarkable growth in the numbers of economists working within the increasingly well defined area of health economics in the 1970 s and 1980s (Ashmore et al. 1989; Colvin 1985). As Ashmore et al. state:

> … there was no *community* of health economists in Britain before 1970; even though there were undoubtedly several academic economists at that time who were professionally interested in health. Since that date an organised community has come into existence (Ashmore et al. 1989: 5).

This growing influence of health economics has major implications for the policy process. The shift in liberal governance created the opportunity for numerous forms of expertise, both new and old, to re-conceptualise their role as regulatory disciplines within a neo-liberal framework. This was doubly important for the discipline of health economics. Whereas health care in the past was always considered to be inherently problematic for economics theory (see Arrow 1963), the work of health economists increasingly made it amenable to a rational, and therefore 'neutral', economic discourse. As stated earlier, the use of 'neutral' expertise provides a regulatory discipline that potentially could begin a process of de-coupling of the state from direct invention in the administration of health care that would ultimately lead to its de-politicisation.

Clearly such an outcome would appear attractive to a government suffering political damage from the perception that their stewardship was damaging to the health care system, as was the case for the Conservative government in the 1980s. Therefore, it would appear that it was in the best interest of government to incorporate the 'neutral'

expertise of health economics into the discussion of health policy. In this respect, with the acquiescence of central government, Ashmore et al. identify three strategies adopted by this form of economic expertise in furtherance of their discipline. The first was an 'educative strategy' designed to persuade health practitioners of the merits of economic concepts when applied to health care. The second, and main strategy Ashmore et al. identify, was to directly influence the policy making process by acting within the health care bureaucracy or acting as consultants to it. The third strategy was to encourage a public debate about the economics of health service provision. The effectiveness of these strategies is clear from the absorption of key concepts from economic theory, such as efficiency and cost-effectiveness, into the mainstream debate about the policy direction for the NHS. The outcome of this influence is that increasingly many forms of analysis unconsciously adopted an essentially economic discourse when discussing health policy. The emergent debate often revolving around the 'reality' of rationing health care in the NHS and whether it is best done implicitly or explicitly - a concept which only has meaning within an economic discourse. However, as Chapter 5 also demonstrated, re-conceptualising health care in economic terms has major implications elsewhere, particularly in terms of the subject of the new health discourse - the relationship with medical expertise and the strategic aims of management within the health care system.

Using a governmentality framework, therefore, emphasises the influence of economics in re-conceptualising the policy arena and points to the functional role of health economists as a group that uses and institutionalises a form of regulatory expertise within neo-liberal health governance. The strategy of health economists (described by Ashmore et al. above) is, therefore an implicit part of a new articulation of policy that re-problematises the governance of health care. However, it is one thing to transform the abstract domain in which political thought is conceptualised, it is quite another to devise practical policy options that operationalise the new problematisation of neo-liberal health governance. This becomes especially difficult when it involves transforming institutions, such as the NHS, which were created as part of the previous form of liberal governance. However, by the 1980s there were many groups, principally on the political right such as the Institute for Economic Affairs and the Adam Smith Institute, who had produced radical plans for restructuring the NHS, for

example through the use of voucher schemes or 'opting-out' of the state system for the equivalent in private insurance cover. However, whilst many of these schemes were considered not to be viable options, they did extend the process of re-problematising health governance in terms of neo-liberal ideology. One of the more influential elements of this re-problematisation was provided by the American academic Alain Enthoven (1985). He suggested that the 'gridlock' in the NHS could be eased with the use of concept of an 'internal' or 'quasi' market within the NHS. In his formulation, consumers would be free to choose a health care provider, modelled on the Health Maintenance Organisation (HMO) system in the US, who would be then free to purchase health care services from whichever source they deemed most appropriate. The only limit on purchasing was the fixed budget allocated to each HMO-type provider.

The idea of the internal market proved to be a potent concept. In 1989, after a six month review process, the government produced the White Paper *Working for Patients*. In this document it was proposed that an internal market be constructed within the NHS. Unlike the Enthoven model, the purchasing function would be assigned to District Health Authorities and Family Health Service Authorities (responsible for GP budgets), with providers formed from existing providers, some given new semi-independent Trust status others, temporarily, to be Directly Managed Units under Health Authority control. In a concession to the merits of the HMO model, some GPs could claim 'fundholding' status and control their own budgets. Many of the consequences of these radical reforms have been discussed in previous chapters. However, although radical policies have been applied to the NHS before, *Working for Patients* arguably reflects a new form of governance of health care. Just as in the 1930s and 1940s a set of circumstances had come together to create a new discourse of liberal governance. In particular, the new role of Health Authorities to purchase health services to meet local health needs widens the debate about the governance of health care considerably. Using the language of economics and especially health economics, the commissioning of services to meet that need implies a form of strategic purchasing that seeks to maximise outcomes given limited resources. Unlike previous forms of management where the aim was productive efficiency, the

new imperative is to produce allocative efficiency. In other words, the setting of priorities for health care spending.

Conclusion

This chapter has placed the development of the NHS within the theoretical context of governmentality analysis. However, as the first part of the chapter illustrated, the use of historical data in support of an analysis that explicitly rejects the notion of narrative does give rise to a number of problems. The two principal problems being the use of periodisation within the governmentality framework and the role played by the policy process in shaping the articulation of governance. It is apparent that the governmentality approach to periodisation and process represents a radical departure from conventional accounts of NHS formation and function. Governmentality analysis emphasises the changing nature of the problematisation of rule that gives the NHS meaning as a locus of regulatory technologies and expertise (both medical and non-medical). In doing so it highlights the discontinuities between different problematisations of liberal governance. However, it was argued that the contingent factors which determine institutional formation often produce a discrepancy between the periodisation identified with one problematisations of rule and the periodisation identified with institutional change. Therefore, institutions such as the NHS, created as a 'solution' to the problems of delivering health care within welfare liberalism, may initially be unaffected by a shift to new form of governance. It is only when a new set of concepts specific to health care governance has evolved that institutions such as the NHS can be made amenable to political calculation within the new problematisation of liberal rule.

The latter part of the chapter described how the 'welfare liberal' formula of governance had shifted in the 1970s and 1980s and had been transformed into a new formula of governance based on ideas derived from neo-liberal economic theory. The implications of this new form of governance in terms of health care have been discussed in other chapters. It was argued that the re-problematisation of governance in terms of economic axioms creates a new range of subjects for the health discourse and produces new technologies of regulation. In particular, the de-collectivisation of

social insurance transfers the burden of risky behaviour on to the individual (see Chapter 3). Therefore, the management of risk also becomes a form of health governance. Additionally, this re-calculation of risk, combined with the new technologies of regulation such as health economics, audit and effectiveness criteria (see Chapter 4 and Chapter 5), produces a potentially more explicit means of managing priorities in the health care system. In the next two chapters further empirical evidence from primary research will be used to evaluate the impact of the reform process initiated by the 1989 White Paper *Working for Patients*, that reflects a neo-liberal formula of health governance. The analysis will focus on new forms of managing the system, including the management of expertise, and the re-conceptualisation of the subject of the health discourse as the basis of the decision making process.

Chapter 7

The local governance of health: discourses and practices

Introduction

The previous chapter described how the NHS has in recent years undergone a radical 'reform' process based on the organisational principles derived from 'free market' economic theory. Given that the Conservative administrations of the 1980s and 1990s were to some degree ideologically committed to 'rolling back the state', the employment of radical free market ideas and the advocacy of market solutions to social problems only exacerbated the concerns of those in the centre and on left of the political spectrum that the NHS, *the* symbol of post-war welfarism, was about to be 'privatised' by stealth. The split in provider and purchaser functions and the introduction of the 'internal market' in health care, inevitably led to the suspicion that this was the precursor to a form of privatisation similar to that which befell many previously state owned enterprises and utilities. As event have proved, fears of privatisation have been largely unfounded. The NHS continued its near monopoly of health care provision and remained state owned and state financed, and true to its founding principle of free treatment at the point of service.

However, this is not to say that the reforms have left the NHS unaltered. The reforms process introduced many new forms of regulatory technology, such as clinical/medical audit, evidence based medicine, contracting - and especially commissioning, which were new to the organisation's cultures (both managerial and clinical) that previously characterised the provision of health care within the Health Service. The novelty of these new organisational structures, combined with the speed of introduction, meant that they were largely untested and their effect on the NHS unpredictable. The research outlined in this and the next chapter, directly engages with the debate generated by the reform process. The findings are analysed in the context of the theoretical framework derived from the Foucauldian concept of governmentality described in some detail in previous chapters. Governmentality seeks to investigate the way in which forms of governance are made tangible realities within a power/knowledge discourse. In this

context, the health reforms of the 1980s, and particular the 1990s, are viewed as marking a shift within the discursive space of health governance. It is argued that there has been a shift away from a 'welfare liberal' form of governance, as represented by the pre-reform NHS, to a post-reform neo-liberal formula of governance.

However, as highlighted in the previous chapter, the use of governmentality analysis has major implications for the collection of empirical data. The problems associated with periodisation associated with the different formulas of liberal rule within governmentality only add to the dilemma of deciding to present data either in support of a snapshot view or a longitudinal study. The difficulty with governmentality in this respect, as already stated, is that the analysis is predicated on uncovering and understanding shifts that take place in the problematisation of liberal governance. When shifts in the problematisation occur so do shifts in the concomitant regulatory discourse of governance and with it the concepts and categories that make lived reality open to political calculation. Therefore, it is clear that conventional historical/longitudinal studies run the risk of misinterpreting the evidence by emphasising continuity when in fact the phenomena under investigation may have changed in meaning and function over the time period of the study.

However, the analysis of change over time is still important to governmentality analysis for other reasons. Again in the previous chapter it was noted that the policy process itself plays an important function in generating the categories and concepts that form the basic discursive elements of a particular problematisation of governance. Moreover, it was argued that the analysis and discussion of policy provides a key locus where new problems arise which are only resolvable through the transition to a new form of governance. However, evidence for this change cannot be obtained simply and directly from primary sources by interview data for example, because this would be in effect the same as asking the respondent to think extra-discursively. Therefore, because of the inherent difficulties of longitudinal evidence within governmentality analysis, the two inter-linked functions for the policy process can only be accessed by recourse to secondary sources. These include commentaries and analysis of the contemporary policy process and longitudinal studies using conventional forms of analysis. Nonetheless, as the previous chapter outlined, using data in this way does imply a

critique of conventional accounts of policy formation by emphasising the functional role academic and other analysts fulfil as a regulatory form of expertise.

An additional difficulty associated with governmentality analysis is that unlike many other forms of analysis employed in the reform debate, governmentality does not seek to provide any external validation of the 'success' or 'failure' of the reform process. In some senses this can be regarded as a weakness of governmentality analysis and Foucault's position in general; an inability to engage in any form of critical normative debate. However, in many circumstances this is also one its strengths. For example, discussing the reform process purely in economic terms, and taking into account the indeterminacy of health as a concept, one can find oneself quickly trapped in a means/ends debate. Would the reforms be declared a success if the actors who inhabit the internal quasi-market exhibited behaviours that closely resembles those observed in free market transactions? Does one just presuppose that health and welfare are being increased as a result? Conversely, would the failure of the quasi-market to approximate 'real' market conditions mean that the Health Service is not efficiently meeting health needs for the population? The strength of governmentality analysis is that this distinction of means and ends is not regarded as a problem. The means and ends are aspects of the same power/knowledge discourse. In the particular case of the health reforms, the means of securing increases in health and welfare through the quasi-market and its associated technologies is constructed within the same discourse that creates subjects amenable to those health technologies, as well as the very notions of health and healthiness.

In Chapters 3 and 5, it was argued that because of the problematic nature of health and health care within traditional economic theorising, health governance was only open to political regulation through the provision of collective welfare and the use of expertise. However, with the shift to a neo-liberal form of governance predicated on the privileged position of market relationships within the political economy, a means had to be found to make health and the health system amenable to regulation within this new discourse. The NHS reform process can best be seen in this context. The construction of the *managed* or *quasi*-market and the other technologies associated with it, represented the process of understanding health in primarily economic terms.

As argued in earlier chapters, governmentality analysis suggests that the subject of this new health economics discourse is no longer the *homo economicus* of classical formulas of liberalism, but more resembles the self-regulating, prudent individual who has a duty to minimise their own 'risky' behaviour in order to reduce the burden they place on society as a result of their actions. The consequence is that those managing the health care system also must address this problem of minimising collective risk. Therefore, risk management becomes a form of governance. A further development of this is that health risk management opens up other dimensions of health other that those defined in narrow clinical terms. Quality of life rather than the absence of disease becomes part of the calculus of health. As a consequence, there is a renewed interest in health promotion and disease prevention strategies.

To investigate these issues in greater detail, it is necessary to undertake detailed studies of health service managers' accounts of their practice. The empirical evidence outlined in this chapter will seek to establish if the concerns outlined above are reflected in the stated rationales of those charged with the duty of commissioning health care in the NHS - District Health Authorities. It will be argued that the role of *commissioning* given to District Health Authorities as part of the reform process embodies many of the key elements of the new form of health governance. The term commissioning as applied to the post-1991 Health Authorities implies a strategic understanding of how to meet local health care needs through the appropriate purchasing of health care. As such it is argued that this new role represents a major departure from the traditional role of management within the NHS. Rather than acting as administrators of the health care system they are now required to be pro-active and willing to instigate change. At the same time it will be possible to comment on other previous studies of post-reform purchasing activity and add to the general debate about the nature of the 'reformed' NHS.

Survey of selected Health Authorities

The empirical evidence in this chapter is derived from semi-structured interviews (n=23) conducted separately with the Chief Executives and principal directors of six English District Health Authorities from two NHS regions. The Authorities were

Table 1 Health authority research sample: key statistics

Health Authority	A	B	C	D	E	F
Revenue Budget 1995/96 (£m)	135	210	115	290	225	225
Local population	320 000	465 000	310 000	720 000	580 000	510 000
% of population covered by GP Fundholding	47%	37%	35%	55%	25%	60%
Position with respect to new funding formula targets	>5% over	2% under	<1% over	<1% under	<1% over	<0.5% under
Locality Funding plans	Yes	No	No	No	Yes	Yes

selected after a review of Purchasing Plan/Commissioning Intentions for 1996/97 from those who authorities that outlined a clear priority setting agenda. An additional factor in the selection process was the authority's anticipated future growth potential vis-à-vis the revised funding formula. A full description of the selection criteria is given in Appendix A. The interviews took place from July 1996 to January 1997. The average length of each interview was approximately one hour. In order to preserve anonymity for those participating in the research, each Authority has been designated a letter from A to F and standardised titles have been employed for individual interviewees. What follows is a brief description of the particular characteristics of each authority (also see Table 1 for additional information).

Authority A was described by its Chief Executive as comprising two distinct populations; one relatively affluent, the other exhibiting many of the problems associated with the inner-city. The provision of health care services was dominated by

a three or four major trusts, the biggest two accounting for approximately 50% of all health authority expenditure in 1995. The authority had anticipated growth monies in line with national average and was surprised to find the revised funding formula calculated that they were significantly over funded. At the time of the interviews the authority was asking for their funding position to be reviewed. Authority A was one of the two authorities in the sample who were actively pursuing a locality funding strategy, devolving the commissioning function to local teams principally made up of GPs' with strategic and financial oversight from the authority. The percentage of the population covered by GP fundholding practices was 47%.

Authority B also consisted of two distinct areas. In Authority B's case the distinction was also geographical. The first area was dominated by a large industrial town with a significant ethnic, mainly Asian, population. The second area was made up of a large town with an above average elderly population. This area also incorporated a large rural hinterland. Each of these areas was dominated by a single large trust which provided many specialist services, several of them regional specialities. However, it was anticipated that with the completion of a major expansion programme of a Trust hospital within a neighbouring district, the neighbouring authority would shift some contracts to their own area and reduce activity in one of the Trust hospitals within Authority B's areas. In terms of financing, Authority B was 2% under-funded with regards to the national funding formula. The population covered by fundholding in the district was 37%.

Authority C consisted of a mixture of rural and urban populations spread over a large area. In addition, it had the smallest population of all the sample of authorities, comparable only to the population of Authority A. The district was dominated by a single large Trust hospital with many relatively new and expanded facilities. Several other Trust hospitals provided services for their local population. Also a significant amount of activity was contracted with a very large Trust in an adjacent authority. At the time of the research a review of acute services for the district was taking place. In particular, the authority was in the process of choosing between two of the smaller Trusts for the site of a new A&E unit, which was proving to be contentious. In terms

of overall funding the authority was marginally over-funded. The level of fundholding was 35%.

Authority D had the biggest population of the sample authorities, covering a large metropolitan area. It had a diverse population expected of a city authority. Like many major cities it was served by several Trust hospitals, many of which had teaching status. Prior to the interviews taking place, the authority had just completed a major review of acute services which in part was a reflection of the problems caused by the duplication of services within the teaching hospitals. Unusually for a major conurbation it was very close to its funding target and thus anticipated average growth. Fundholding was high at 55%.

Authority E had the second largest population divided between three distinct areas each with an urban centre and associated rural population. All of the areas were served by a major Trust hospital but many services were purchased from a neighbouring authority that acted as the regional centre for specialist care. With the abolition of the regional tier of management a proportion of the authority's funding allocation was 'top sliced' as a regional levy in part to meet the expense of running the teaching hospitals in this neighbouring district. Additionally, the authority was in the process of rationalising its own acute service in the three districts which was proving to be politically difficult. This authority had by far the lowest level of fundholding in the sample at around 25%. In terms of funding allocation it was slightly less that 1% over target.

Authority F was a predominantly urban authority covering several large towns but with a significant rural population. Within the district there were several large Trusts serving distinct populations. Many specialist services were purchased from Trusts in neighbouring authorities or from two reasonably near regional centres. At the time of the research there were no discussions about any radical rationalisation of acute services. Like authority A, this authority was actively engaged in a form of locality funding working with both fundholding and non-fundholding GPs to commission services for their local populations. The level of fundholding was the highest in the

sample at 60%. In overall funding terms they were less that 0.5% under target, so anticipated average growth in the near future.

It was a function of the selection procedure to include as many variables as possible within such a small sample of six authorities. Within the sample there are several different types of authority - city, urban/rural etc., a range of population sizes, variable levels of GP fundholding. Additionally, two of the authorities were committed to locality funding with one discussing it as a future option. In terms of funding, three authorities were below their target allocations and three above target, one significantly so. However, with the exception of authority A, it has to be noted that most of the authorities were relatively close to their targets so it is a moot point whether this variable is meaningful in the context of this study. The initial selection process relied on information from authority Purchasing Plan/Commissioning Intentions for 1996/97. However, at time of going to press the authorities had not received official notification of their allocations for financial year 1996/97 and so had to indulge in speculation as to future growth monies. Therefore, the implications of the funding formula had not at that time been fully assimilated and incorporated into future funding plans. As it turned out, 1996/97, being a pre-election year, the allocation for the NHS was a little more generous than anticipated.

Health Authority structures and organisation

The 'reform' process instigated by the *Working for Patients* white paper (DoH 1989) officially began in April 1991 with the creation of the 'internal market'. Contracting in the first year was restricted so that a 'steady state' could be maintained until purchasers became more comfortable with their new role within the 'reformed' NHS. Subsequent years saw a relaxation of controls as purchasing authorities developed new organisational skills needed to operate within the internal market. Many studies have described this changing role of purchasing organisations in the early stages of the reform process (see Appleby et al. 1992; Appleby 1994; Freemantle et al. 1993; Ranadé 1995). The new role of purchasing was accompanied by changes to the purchasing organisations themselves. Many health authorities merged with their neighbours leading to a significant reduction in the total number of authorities. In 1991

there were 190 Health Authorities, by 1994 there were 108. To illustrate this, in Ranadé's (1995) study of purchasing organisations as they were constituted in 1990-91, the authority with the largest population in her survey at 309,000, is equivalent in size to the authority with the smallest population of the sample authorities, authority B, who considered themselves a comparatively small authority (see Table 1). Additionally, Health Authorities and Family Health Service Authorities (FHSAs) were merged in April 1996 to produce single authorities responsible for the full range of purchasing. At the same time as the average size of Health Authorities was increasing, the level of GP fundholding was also increasing and becoming an important factor in overall purchasing activity. By 1994 the proportion of the population covered by fundholding was 36%, by 1996 it has risen to around half the population (Audit Commission 1996; Ranadé 1997). Another significant change was the level of services provided by organisations with trust status. The initial wave of trust applications accounted for approximately 13% of NHS expenditure. This had risen to 95% by the fourth wave in 1994 and 98% in 1996 (Smee 1995).

The significance of the statistics highlighted above is that the empirical interview evidence to be presented in the rest of this chapter describes a time of relative stability for health authorities. Taken as a whole, 1996 marked the first opportunity to see the purchaser and provider functions clearly delineated. The strength of the research is that it describes a relatively mature process of purchasing at work. It is worth commenting that all the authorities included in the research sample above are still in the same configuration at the time of writing (July 1998) as when the interviews with directors took place in 1996/7. By 1996, when the initial interviews took place, the level of merger activity had declined from its peak in 1991-94. Each authority had already merged with their FHSAs. There were no Directly Manager Units (DMU) providing health care in the district. Contracting arrangements had been in place for several years and GP fundholding was an established practice in all districts. Moreover, the purchasing role was beginning to move out of the shadow of the supply-side provider interests that had dominated the thinking of policy makers when the internal market was created (see Ham 1994). As Hunter states, the initial reform process was 'almost exclusively concerned with introducing supply-side changes without really attending to the question of what the changes were actually for' (Hunter 1993: 33). Therefore,

because of its original inchoate nature it becomes doubly important to examine how the role of purchasing has developed within the 'reformed' NHS and, more importantly, to ascertain to what degree this developing role was informed by a coherent rationale.

Organisational structures: commissioning local health care services

In an earlier study of eight purchasing authorities, Freemantle et al. (1993) distinguished between two distinct organisational structures; one dominated by directorate function (finance, public health, planning etc.); the other having a flatter managerial structure with more cross directorate input into the decision making process. To some extent the evidence from the current sample of six authorities on the whole supports this analysis. However, there is one major difference. All of the six authorities in the survey described their current managerial structures in terms of having moved, or were in the process of moving, away from a rigid directorate structure to the cross-directorate or 'mixed matrix' model described by Freemantle et al.. Additionally, some authorities had the extra dimension of locality based commissioning. The comments below of a Director of Commissioning were typical of the responses to questions of management structure. As he states:

> There is a 'before', and a current consideration of 'how it will be'... Purchasing activity has previously been delivered through the finance director. And it has been very much an efficiency, financially specific hospital based hospital contract, type of approach. And because of the financial problems of [in the city], has in a sense, not been integrated with the other agendas. To the authority's credit, it was recognised in the change on the 1st of April [1996], so what we have come up with is a different kind of structure and a different approach to create, I think, much more integration - so the end result reflects much more where we are trying to get to... We are moving towards what we are calling a commissioning team approach, which is to take certain specialities or certain services, and identify a relatively consistent group of people who will bring together the necessary skills and perspectives as a commissioning team. In most of those instances we will devolve the budget for those specialities or services to that group of people... So it will include someone from the market management part of my directorate. It will include someone from finance. It will always have a public health doctor in it. And that is the core team of people. It will have others as appropriate (Director of Commissioning, HA C).

This cross-directorate approach also extended to the management of locality commissioning. The Chief Executive of authority F described a situation where 'directorates mix and blur', with locality managers recruited from different departments. Although each authority had a slightly different management structure, the rationale behind changes in management organisation remained constant. This was a desire to deliver what was described as a 'change agenda' that focused on the broader concept of 'commissioning' instead of the 'technical' exercises of purchasing and contracting. There was unanimity between authorities that this distinction was more than a mere question of semantics. The authorities perceived their primary role of commissioning to be the development of a strategic overview in order to meet health needs in the district and this was done through the operation of effective and appropriate purchasing and contracting.

However, it is evident that using the term 'commissioning' is open misunderstanding and will need some additional clarification. As described earlier in the chapter, one of the strengths of governmentality analysis is that it is sensitive to changing meaning of categories and concepts within the discourse of governance. The idea of commissioning is one such concept whose meaning has changed along with the discourse of health governance. The term commissioning is not new to health service management. In the pre-reform NHS many new services or facilities were 'commissioned' as part of the continual development of the health service. However, in the post-reform NHS, it is argued that commissioning has taken on a new meaning. At the very least commissioning can be viewed as a form of strategic purchasing. However, strategic purchasing implies a new set of goals for health service management, in particular for managers within District Health Authorities given the new remit of meeting local health needs. The concept of health needs itself entails a wider understanding of health to include non-clinical values. Indeed Paton (1996) defines the commissioning criteria as reflecting:

> the desires of patients; the desires of the public more generally; the opinions of general practitioners; the opinions of a whole range of professionals, health and otherwise; and cost or cost-effective considerations (Paton 1996: 134).

The notion that commissioning is qualitatively different from the technical function of purchasing or contracting was also reflected in the interview data with health authority directors. The comments of the Director of Public Health below are typical of a 'holistic' understanding of commissioning expressed by respondents in all Authorities:

> Commissioning is strategic overview, but also much more involvement with other agencies. Whereas contracting tends to be only those we are actually giving money to. If I could put it as crudely as that (Director of Public Health, HA C).

However, it was also acknowledged that there was still a great deal of confusion and fluidity of terminology about commissioning, purchasing and contracting. As one Director of Commissioning stated:

> I hear about colleagues in other commissions or other health authorities ... [they] don't seem actually to my mind to be commissioning. All they are doing is purchasing. We can all purchase... but if you are actually really wanting to influence and change health care, and improve quality of health care then you've got to get into some of the rather difficult, more exposed debates with clinicians (Director of Commissioning, HA A).

As the above illustrates, the 'strategic' nature of commissioning implies forging new relationships with other agencies, with the medical profession and with local people whose health needs are to be met. However, it was clear from the interviews that the Health Authorities were still evolving a language of strategic planning that could conceptualise their new role in a coherent way. As part of this process all the Authorities were engaged in changing their management structures in order to operationalise their new strategic function. As one Chief Executive stated:

> Basically you have a choice for structure between a system which is strongly process dominated. It really gives you the traditional pattern of uni-disciplinary departments each headed by a director which are very good at delivering the process side of the agenda. So you would, for example, have a director of finance, you would have a director of planning. They would be very good at making sure that all the financial processes are followed or the planning processes are followed. The weakness of that sort of structure is that you tend to get little cross

fertilisation from one directorate to another. And also that our core business is health, our currency is health services, our key stakeholders are by and large professionals, usually medical professionals - so hospital consultants, general practitioners, other health professionals - and indeed patients who do not think in terms of directorates of finance and planning and things like that. They think in terms of either healthcare systems, like acute services, or more specifically individual services (Chief Executive, HA C).

Therefore, whereas the old management structures were seen to be process-driven, or more specifically finance-driven, the new forms of management structure, which all the authorities in the sample were moving towards, appear to privilege the more strategic commissioning function. Moreover, to further this agenda of (commissioning health services to meet health needs) it was argued that this was best delivered by the Public Health directorate or a directorate for strategic planning. As one Chief Executive stated, 'what we are trying to achieve... is placing actual contracts with providers, that process should be very much informed by the work of the development directorate, and particularly the Director of Public Health'. As a consequence of moving on to this Public Health agenda, the rhetoric of meeting health needs and of 'health gain' effectively opened up the concept of health to include the potential for pro-active interventions by strategic management. The use of health promotion and disease prevention strategies, focusing on 'risky' behaviour indulged in by individuals, clearly resembles the 'New Public Health' concept mention earlier. As one Director of Commissioning argued:

> The strategic framework, and a lot of the work that supports that, is about trying to change the language and change the approach... You are actually using different language about health gain, for instance, which is important language. But then, within that we are talking about personal responsibility for your own health, how do you involve local populations in that debate, how do you make people aware of their responsibilities, what responsibilities do they have to the health service in their use of the health service? Then you are moving on to their opinions about priorities because you are obviously not going to be able to do everything, which is the rationing debate (Director of Commissioning, HA E).

This last statement inevitably leads to a set of problems about how this strategic vision is operationalised within the post-reform NHS. In particular, how does a public health led purchasing agenda fit within the confines of the internal market? What will be the consequences for provider competition within the market? In Chapter 5 it was observed that when policies derived from a market based rationale are used in situations that have hitherto resisted economic theory, the solutions involve the creation of measures that act as proxies for economic concepts. Often this results in adverse effects, privileging efficiency above equity and aggregate needs over those of the individual. This is because the subject of these constructed economics discourses are not the rational, self-interested individuals of classical economic formulas, but intersections of risk factors that personify the individual. Taking this to the next level, one could speculate that if individuals are only amenable to a regulatory economics discourse through this calculation of proxy variables, then the reformed NHS and the role of purchasing are equally constructed within the same discourse. Therefore, just as individuals are regulated within a form of health governance then one would expect that the activities of purchasing authorities would be managed through the calculation of a different set of proxy variables that increase political regulation.

This form of health governance has already been alluded to with reference to the Osborne (1997) in Chapter 3. He argues that neo-liberal forms of health governance depend on the production of 'surrogate' variables 'that will stand measure for otherwise abstract ideas of health... Neo-liberalism abandons the quest for an absolute that would be 'health' and opts for determinant strategies, targets and specifics instead' (Osborne 1997: 185). However, what is not clear is the extent to which politically useful surrogate variables - ie reductions in length of waiting lists, efficiency indexes, the *Citizen's Charter*, *Health of the Nation* targets and so on - compromise the delivery of the purchasing authorities' strategic agenda. What the construction of a regulatory economics discourse seem to be have created is not one single coherent form of health governance but a multi-layered form of governance that works on several distinct levels within the overall governance of the health service. There is the 'micro' level where providers compete with each other within a form of managed market in health care and where medical specialties within provider organisations compete with other specialties for resources. There is a 'meso' level where health

authority purchase health care as part of a commissioning strategy to maximise 'health gain' within their local population. And there is a 'macro' level of government regulation that seeks to demonstrate effective stewardship of the health system as a whole. Each one of these levels of analysis of the 'reformed' NHS can be said to reflect a neo-liberal form of governmental discourse. However, because the discourse in effect constructs a market where none has previously existed, each level of governance has to have its own set of proxy variables which may or may not be consistent with each other. In order to understand and explore the potential for conflict between these levels of governance it is valuable to concentrate on the meso level of analysis and the rationale of purchasing authorities. This level of governance forms a bridge between the other two levels. The meso level is where macro policies are operationalised and micro level problems are negotiated. Therefore, the later sections of the chapter will deal with purchaser attitudes to central government imperatives, but the next section discusses purchaser/provider relationship both through the formal mechanisms of contracting and through other non-market relationships.

Contracting and the internal market: local discourses and practices

As many commentators have theorised, the introduction of the purchaser/provider split and the notion of competition within the health care system has the effect of placing the internal, 'quasi'-market as the 'radical core of the NHS reforms' (Ranadé 1995). Therefore, when discussing the quasi-market phenomenon in this theoretical context, it is not surprising that contracting as the open expression of market exchange has also become central to the debate on the reform process. As Flynn and Williams (1997) assert, 'contracting in the NHS has evolved as part of a fundamental restructuring of the welfare state' (1997: 1). Furthermore, given that the concept of the market and market exchanges are the life blood of economics it is perhaps inevitable that the quasi-market and contract literature has been dominated by an economic understanding of market behaviour. As Le Grand (1991) observes:

> There is much yet to be discovered about quasi-markets... In many ways the present government has made a gift to economic analysis, both standard microeconomic theory and more recent developments such as transaction cost analysis (Williamson 1975, 1985). It has also provided

> a set of quasi-market 'experiments' against which to test those theories (Le Grand 1991: 1267).

It is relevant to note the use of Williamson's transaction cost analysis as an alternative way of theorising market relationships. As discussed in Chapter 5, the ideas of the 'new institutional economics' associated with Williamson seek to understand institutional behaviour within the context of complex and problematic markets. New institutional economics suggests that when institutions are faced with certain failures of the market - through information asymmetries, for example - that it is a rational, efficient market response to internalise the provision of services within the institution's hierarchy. In effect, the institution makes a rational decision that the transaction cost of generating enough information to minimise the risk of malfeasance and opportunism dealing with external contractors is greater than the potential increase in inefficiency of providing the service internally. Obviously this has direct relevance for contracting with the NHS internal market. It could be argued that the complexity of economic calculation within a comprehensive health system, like the NHS, is so great that the process of efficient contracting is outweighed by the transaction costs of producing contracts. In economic terms this is a strong argument. However, it still essentially presents an overtly economic rationale for market behaviour.

As noted in Chapter 5, recent decades have seen a more sociological body of literature develop that re-examines the role played by social relationships in economic action. The ideas of Mark Granovetter (1985; 1992) represent such a reformulation of the basis of economic action. As stated in Chapter 5, he argues that the embeddedness of economic action in social relations through networks of concrete, personal relationships introduces a new flexibility into models of economic behaviour. He suggests that institutions do not necessarily face the stark choice of external contracts versus absorption into the organisational hierarchy. Using the concepts of networks and embeddedness, contracting becomes a more sophisticated process. At one extreme there is a 'hard' form of contracting that equates to the atomistic, spot-market, of standard economic theory. At the other is 'soft' contracting which takes account of pre-existing social relationships. In this soft form of contracting contracts take on a more symbolic meaning, reinforcing existing relationships based on well-founded

expectations of trustworthy behaviour that counter the need for highly specified contract negotiation. This nuanced approach to contracting causes a number of problems for the testing of economic theories that Le Grand suggests quasi-market policies represent. If contracts within the quasi-market do not develop beyond the simple description of agreed activity, such as block contracts in the NHS, this is strongly indicative that the quasi-market has in some way 'failed'. However, the implication of the concept of embeddedness suggests that simple contract relations may be coupled with sophisticated relationships that enhance the delivery of services. Without this extra sociological information the picture is incomplete. The research findings outlined below engage in this debate by exploring the nature of the contract relationship and adding to the knowledge of purchaser/provider relationships revealed by other studies of contracting (see Flynn and Williams 1997).

Contracting, purchasing and commissioning

It was noted earlier that the purchasing element within the NHS internal market was one of the least developed aspects of the reform process with 'no set values... clearly enunciated to guide and to legitimise purchasing procedures' (Salter 1993: 171). In this respect it is interesting to note how official guidance to purchasing authorities gradually changed as the internal market developed (see Flynn and Williams 1997). The earliest guidance from the Department of Health (DoH 1989) reflected the rhetoric of the market and included injunctions against monopoly behaviour or the forming of cartels that would distort the internal market. However, at the same time, it was emphasised that the market is a means to an end, not an end in itself. The ultimate aim of the reform process is to provide a better NHS. Hence the call to both sides of the purchaser/provider split to work in such a way as to 'maximise the total quality and quantity of service' (DoH 1989: 16). It was not until 1993 in a series of speeches by the then Minister for Health, Brian Mawhinney, that a clearer articulation of purchasing function emerged. The speeches outlined seven steps for purchasers for making 'tangible improvements in people's health' (Mawhinney 1993: 24). They included:

- strategic planning
- effective contracting to achieve improvements in quality and efficiency
- knowledge-based health care
- responsiveness to local people
- cooperation with providers
- local alliances
- appropriate organisational capacity

The advice contained in the 1994 guidance document (DoH 1994) reinforces many of these points. Especially important was the suggesting that 'constructive cooperation' can complement competition for the overall betterment of the Health Service. In this formulation of the relationship between purchaser/provider one can see a tacit acknowledgement the limits of competition when faced with the problem of a market in health services. The difficulties of monopoly supply, monopsony (where there is a single purchaser), uncertainty about outcomes, principal/agent problems and so on, all apply to the provision of health services within the NHS. It is suggested in the guidance document that ideas of 'contestability' could be invoked in order to stay true to the market ethos. Contestability suggests that some forms of monopoly provision are permissible because, in certain circumstances, the whole service could be subject to challenge from another supplier, and hence open to competition. These circumstances occur when there are low or no 'sunk' costs or barriers associated with entry into or exit from the market (Baumol 1983). Clearly some health provision is highly contestable and many of the sample authorities mention market testing of some services. In general, those services tended to be of a specialist kind, such as a drug addiction service one authority contracted with an independent organisation. However, more typical of the responses from the authorities was a discussion of the potential benefits of a threat of exit might bring about rather than increases in competition. For example, as one finance director stated:

> One of our hospitals is under-performing on its eye contract, and on the number of cataracts it does. One of the things we've said is that we are looking at possibly bringing a third party into the district to do cataracts. Now that seems to have motivated on face value, at least the

> leading consultant, towards trying to make up the contract deficit (Director of Finance, HA B).

This director qualified his comments by suggesting that in general it was not realistic that you would not place the bulk of contracts with the local major trusts. However, he went on to argue that it was sometimes important to put providers on notice that the purchaser/provider relationship had to change and the authorities were serious about their intentions. As another Director of Finance explained:

> We went through a process early on of market testing a few services just to show the providers we are willing to do it. And we market tested dental services and a few others, and we did save some money on those and that was reinvested in something else. But I think it was more about a process of just the providers at the time were quite cocky about, 'well you just have to give us your money, don't you'. So we said, 'no we don't. We'll do this. Sod off'. And they got a bit twitchy and it was quite entertaining. But we did it and the upshot of that was it changed our relationship with providers and we got into a much more mature relationship about those discussions. Not the, 'we'll provide whatever we feel like and you'll pay it... This is what we need. We need to provide you with this'. And we are saying, 'well maybe that's not necessarily what we want'. And we get to a much more vigorous debate now and we'll even debate about what needs to be done (Director of Finance, HA A).

The question that now arises from this statement is what role the contracting process plays in this 'mature' relationship between purchasing authorities and providers. It was evident that all the authorities in the sample were following official guidance and moving towards more 'sophisticated' contracting (see NHSME 1993). That is to say, they were moving away from 'block' contracts and adopting a mainly 'cost and volume' approach to contracting, supplemented with a few specialist 'cost per case' contracts. However, as the comments of the Chief Executive below suggest, the move towards more sophistication was more an exercise in pragmatism that anything else.

> [Contracts] have become more sophisticated, more detailed, we've broken them down more. They are a lot more sophisticated. We try not to be silly over some contracts - A&E, for example is a block contract... But for some contracts, breaking them down doesn't make sense. You can do an enormous amount of work and achieve very little.

> Where others you need to know a great deal about (Chief Executive, HA F).

In a quasi-market context this shift in contracting type *could* be seen as evidence of success. Block contracts, which characterised the earliest forms of contracting, are essentially the safest option for purchasers. They place the financial risk of miscalculating demand onto the provider. However, while block contracts give the purchaser a degree of financial security there has to be a trade-off against the ability to monitor the delivery of the contract by the provider. At the other extreme, 'cost per case' contracting has the opposite problems. Contracts are easy to monitor but it is the purchasers who face the financial risk if demand for the service is greater than anticipated. Additionally, monitoring involves some form of transaction cost which has to be included in the overall equation. The 'cost and volume' type of contract in effect is a compromise between these two positions. It shares financial risk between the purchaser and the provider and is easier to monitor. This question of risk and monitoring re-emphasises the role that trust plays in purchaser/provider relationships. Purchasers who depend on block contracts could be characterised as having a low risk/high trust relationship with providers: a low risk of financial problems for purchasers but also having to be reliant on providers not to indulge in opportunist behaviour. In contrast, 'cost per case' contracting implies that purchaser/provider relationship involves high risks but low trust. It is the *process* of contracting that forms the mechanism which limits provider opportunism. So it could be argued that the closer contracts resemble the cost per case ideal the more purchaser/provider relationship resembles a market interaction.

The immediate problem for the formulation of the contract/market relationship outlined above is that the evidence from the sample authorities suggests that contracts were coalescing around cost and volume type. This was exemplified by the comments of this Director of Finance.

> Yes we started with all block contracts. We very quickly moved into cost and volume contracts. We very quickly thereafter moved into the cost and volume contracts within indicative targets for each speciality and that was basically for all contracts. If there wasn't a contract of that

shape, it was a hybrid of that or it was ECR's. There are some contracts where the base contract is, most of the contract is stable. So we just say yes, we have those indicative targets but we won't cost and volume around it because the risk is minimal and there's no point in it. But there are these specialities where there are risks involved for both parties so we put a cost and volume target onto that. A hybrid of some description but it is not a pure block because every speciality has a indicative target (Director of Finance, HA A).

In general, the responses indicated that contracts represented a search for stability rather than wholesale endorsement of competition. In one authority there was a conscious decision to keep block contracting despite pressure from Trusts to move to cost and volume. As the Director of Finance stated, 'we have relatively unsophisticated contracts but relatively sophisticated relationships'. The indications were that the relationships that were being formed through contracting were of a more long-term nature. This comment from a director of strategy was typical:

> We've done two things. We've moved to a longer term package with the hospitals. So with the Community Trusts now we have a three year package that gets rolled forward, and it includes within it service developments, but balanced with efficiency savings. So they get a longer term perspective and we negotiate around the margins of change, depending on our priorities. And other priorities which have come up from GP discussions.... So there has been a move towards a longer term total package. And there have been individual service changes around service frameworks and specifications. But the more general move has been that longer term thing (Director of Strategy, HA D).

Clearly stable, long-term relationships embodied in contract obligations do not resemble the active market envisaged in the early reform process. However, to counter this there is some evidence that GP fundholders as purchasers (who generally have cost per case contracts) do have a more dynamic relationship with providers, which is reflected in treatment price (Glennester et al. 1994; Propper and Bartlett 1997). On the whole, the evidence from the sample authorities suggested that applying purchasing leverage to reduce treatment price was not one of their major objectives. The search for stability outweighed competition. So it is no surprise that the authorities in the sample did not see contracting as their most important activity. Contracting was

described more as a technical function done at the end of the year, a process through which commissioning was operationalised and financial 'reality' brought to bear, as these comments suggest:

> Contracting, at the end of the day, is the mechanics of turning commissioning into reality, isn't it. Commissioning is actually deciding the shape of the services you want and the content. We approach commissioning - we essentially have a commissioner board which included Directors of the health authority and GP representatives. At the end of the day health authority makes decisions on the shape of the services we buy, and particular in the area of change we are looking for. Where contracting is essentially the mechanical process at the end of it of agreeing the figures and the activity issues and negotiating (Director of Finance, HA B).

> Contracting is just a piece of process at the end of the line that enables us to agree activity against a financial commitment for the services that we wish to buy. So it's process, it's not a central function if you like. It's a function that we have to do once we've decided what health care we want, how we want it delivered, how much it costs and how much of it we want. We then set all of that in the context of, 'and by the way provider here's your money and for that we expect that' (Director of Commissioning, HA A).

This differentiation between the technical process of contracting and the strategic process of commissioning was a consistent theme repeated by all the sample authorities. Indeed it was striking that many of the non-finance directors consciously distanced themselves from the contracting process to avoid the technicalities of contracting compromising the commissioning function. As these directors of commissioning stated:

> I mean I do not see myself as contracting. I see contracting as a support function. I see it as a function that takes place in another directorate... we don't get driven, if you like, by contracting. Although occasionally information through the contracting route about excess activity in a particular service, or whatever, might give us rise to do a piece of commissioning work. But generally speaking it should be the other way, it should be commissioning driving contracting, and contracts should change in answer to pieces of commissioning work (Director of Commissioning, HA A).

I suppose that the first thing I would say is that, and I will overstate this, I'm not concerned in the slightest about purchasing. And to a lesser extent about contracting. What I am particularly concerned about is commissioning as a new health authority. In that, the change we are trying to bring about is to see the purchasing and contracting approaches… match with the commissioning strategy (Director of Commissioning, HA D).

It appeared that within the terms of reference of what they saw to be their commissioning remit, the sample authorities did not place a high value on competition within an internal market. Moreover, they saw the commissioning function as more than just demand management. Commissioning also involved managing supply. In this context the internal market is actually an obstacle to the efficient distribution of resources. Trusts are in effect in competition with each other. They are in the business of increasing activity not decreasing it. In the light of this, is was clear that contracting was an important 'lever' for the authorities in matching supply and demand and in particular, countering so-called supplier induced demand. As the two examples below demonstrated, contracting was seen as a means of constraining Trust activity.

> We've got a bit of a row running with the Trusts about sleep apnoea. And we've said, 'we're sorry but we didn't ask you to develop this service. We've never wanted it. What little we need in that area we can get elsewhere. Thank-you very much. We are not going to pay for it'. They leap up and down and say we have invested all this money in it, and we say, 'tough'…(Chief Executive, HA F)

> What we have to steer clear of, it's crucial, is that they don't market the service to the GPs, and the GPs start referring to a new service…it causes hellish problems if they are actively and aggressively marketing the GPs and the GPs are saying 'yes refer them there, they provide that', and we may already have an existing contract with them but it may not be for that particular service that is being marketed. And that is happening more and more and more (Director of Contracts, HA C).

The irony in both these examples was that Trusts were being admonished for acting in the spirit of the reform process. The internal market is predicated on provider

competition. Again this calls into question the authorities' commitment to competition within the internal market.

Contracting and Trust regulation

An additional aspect of contracting that the sample authorities utilised was its property as a technology of discipline. In this respect contracting does not stand alone but works in conjunction with a host of other technologies. The three that were cited most often were audit, accreditation and 'care pathways'. These forms of disciplinary technology all to some extent fall within the scope of 'evidence based medicine' (see Chapter 4). The key technology on which the others to some extent depend is the audit process; the principal means by which evidence of effective treatment is established in the care system and the means by which adherence to guidelines and protocols is monitored. Only when this process has been gone through can its findings be incorporated into contracting. As this Director of Primary Care observes:

> Well our GP non-exec. would say we should only be buying or contracting with people who deal with audit as part of their everyday business. It should be part of their core service... They shouldn't be doing any practice that isn't based on audit work. Now that's a nice utopian view and we need to get to that, but I think that we have a lot of practices in primary care who don't audit, we have a lot of people in secondary care who only audit the bits that are interesting to them... audit should be part of a reporting mechanism as far as I'm concerned (Director of Primary Care, HA A).

Accreditation is a variation on this procedure. The most prominent accreditation model available at the time was that produced by for cancer services (based on a report by Kenneth Calman, Chief Medical Officer). Instead of individual clinicians being accredited, a nexus of people, facilities, equipment are given accreditation for a defined period of time. The provider has to rearrange the division of labour within a specialty, perhaps introducing a sub-speciality consultant and so on, in line with recommendations. As one Chief Executive stated, 'I think it would be very difficult for a health authority to commission services once this process has been completed from a non-accredited surgeon in the field of cancer'. Other respondents were more sceptical

about its general usefulness as a model and were worried that it might build unavoidable costs into the system, would be bureaucratic and hard to monitor. But on the whole most saw merit in the accreditation process.

> I think that's where we are going. I mean on the primary care side that is clearly going to start happening more and more as we get primary care taking on minor procedures, shall we say. I suppose I am not optimistic that we will move that fast on it simply because, how would we accredit? Who would we have in our resource to actually monitor? You know what I mean. I suppose that is a worry. Encouraging organisations to set up accreditation processes by peer review from external [reviewers]- great! If that is what we are saying. It's that second bit, but it feels like it's encouraging (Chief Executive, HA D).

Those authorities that were interested in expanding the accreditation model also noted that if it was possible to accredit then 'disaccreditation' was also a possibility. In effect it would be the equivalent of the threat of exit that exists with contestability. However, the same problems would apply to disaccreditation as it does to exit, perhaps even more so. The accreditation process by its nature involves a commitment from both providers and purchasers, both have to commit time and resources to set the framework in place. Therefore, given this commitment it is a moot point whether disaccreditation would be a viable option in disciplining providers. It is the monitoring of the accreditation criteria that forms the basis of provider regulation.

The idea of 'care pathways' is similar to that of accreditation. In effect it involves a series of services each of which are accredited or agreed through audit. Taken together they create an holistic approach to a service, looking at the whole care package from entry until exit from the system. For the most part this form of defining the type of service the authorities wished to purchased was being actively pursued only by only a few authorities in the sample. And of those, either it was part of their future plans for purchasing or it was reserved for particular forms of service. One example was maternity care.

> We are already moving towards that in certain areas, but it's not an easy one to get too far into, because you are into all the inherent problems within the service of being able to cost for that pathway

properly, and how well can we identify those services. That's a problem for the Trusts rather than us in a sense. But in principle we are - for instance, particularly maternity services, where it is sensible to see a pathway right through from primary care, right through to potentially up to tertiary care for the very sick babies, but predominantly into the secondary area. It would almost be a package of services available for maternity (Director of Finance, HA E).

It was argued that one of the attractions of care pathways for the purchasing authorities, as suggested by the above comment, was that the particular care pathway model was produced by the Trust not the authority. The Trust had to commit resources to develop a fully costed and audited pathway with built-in monitoring procedures and only after this was done would the authority decide whether to purchase the service in that form. The additional advantage was that it provided a mechanism for highlighting any substantial deviation from the agreed treatment methods. Potentially, an individual clinician that consistently strayed from the pathway would be noticed and their actions scrutinised. As many respondents noted, this form of discipline through contracting with Trusts was one of the few levers that the authorities had at their disposal to control clinical behaviour. However, at the same time there was a marked reluctance on the part of authorities to use exact contract specification except as a last resort when all else had failed. Interestingly it was the Directors of Public Health that showed the greatest reluctance to use formal sanctions, preferring informal consultation and peer pressure to bring about a change in clinical behaviour. Chief Executive and finance directors were more willing to use the Trusts as employers to make the change. As an illustration of this, a Chief Executive was given the scenario of a consultant who appeared to be performing too many grommet operations to correct glue ear, and was asked to comment on the authority's response.

> Well we say to the Trust, 'with reference to the contract we have with you, we've calculated the cost of grommets. We're not going to reduce your contract by that much, but we want some more of another thing. Now if you are stupid enough to go on underwriting this guy doing it, that's you problem. But we wish you to know that's not the way we want' (Chief Executive, HA F).

However, this comment, and similar ones made by other non-Public Health directors in response to this scenario, was almost always followed by the admission that so far it had not been necessary to do this. More often than not, problems were resolved by discussion with the Trust's medical director and a 'sensible' agreement was achieved. Often this agreement was reached after additional pressure was put on Trusts by GPs at the prompting of the authority. It was, as one Chief Executive put it, a case of 'more men with stethoscopes round the table rather than men in grey suits' being more persuasive when dealing with clinical behaviour.

The problem with the above discussion of the disciplinary nature of the contracting process, and its associated technologies, is that there is a danger of overemphasising the confrontational element of the purchaser/provider relationship. At times focusing on this dimension of relationship acts as a corrective to earlier studies that describe an internal market dominated by providers (see Freemantle et al. 1993). While it is undoubtedly correct to say that the authorities in the sample were concerned about provider activity, the impression was not of authorities having been 'captured' by providers. Indeed, it could be argued that the authorities felt it was part of their commissioning role to give Trusts some protection against the vagaries of the internal market. For those authorities undergoing a rationalisation of acute services it was seen as a particularly important part of their strategic remit to not only manage demand but also manage supply. Clearly authorities cannot manage demand as they would wish without the co-operation of local GPs, including fundholding GPs. To further this, in all of the authorities there were formal and informal mechanisms of eliciting representative views from GPs and including them in the commissioning process. Locality management is perhaps the most formal strategy of all to incorporate GPs, fundholding and non-fundholding, into commissioning. Although the role of GPs in setting commissioning priorities will be discussed more fully in the next chapter, it is important to note the ambivalent relationship patient-centred GPs seemed to have with the strategic commissioning process. GP opinions are fundamental to the commissioning process that determines the mix of services the authority decides to contract. As this comment by a Chief Executive illustrates:

> One reason we have been close to GPs is because of the major reorientation of services... and of course we don't refer patients, it's GPs that refer patients. So if we move contracts from one place to another to commission major new services..., unless the GPs are signed up to those changes then of course they won't happen (Chief Executive, HA C).

The problem for the authorities, as they saw it, was that strategic thinking has never been part of the GP job description. Therefore, it was seen as central to the authority's commissioning remit to 'get some of the 'God's Eye' picture through and actually move the District'. And this meant guaranteeing amounts of business to Trusts to keep them viable and to match the demand for health care services expressed in contracting. As a director of strategy observed:

> Sometimes you have to say [to GPs], 'think it through what will happen, and think it through what you want to do with that contract'... there will be some priorities that will be important to them, which we think 'well that is not a strategic priority really'. And there will be others, to us - for example, one of the dilemmas was on junior doctors hours - which I actually feel is a worthwhile priority, and I know it is provider focused... Now GPs are just saying that is nothing to do with us, that is Trust business. Let them worry about that. So, we have to find a way of getting them to understand the implications of us not doing that. And the way you do that is to make it very practical for them. So, for example, you say, well in some of the smaller surgical specialties, if they don't do this they will lose accreditation, if they lose the accreditation they lose the Senior Registrar. If they lose the Senior Registrar, it folds in that hospital (Director of Strategy, HA F).

What was clear was that the authorities in the sample were well aware of the new possibilities that the reform process had given them to make strategic decisions and influence the health agenda. All the authorities felt that that they had many more instruments to make change than they had previously and were on the whole optimistic about making real and substantial changes in the mix of services in the long run. As one director of commissioning stated, 'my job more and more is trying to build the things that are levers for change... Which for me was what commissioning was about'. However, it is equally fair to say that the authorities in the survey still felt that making changes was difficult, and only really possible at the margins of activity. Moreover, they asserted that many of the obstacles in the way of making strategic changes were

not because they were ill-equipped to meet the challenge but, more relevantly, there were perverse incentives built into the system that preventing them from fulfilling their remit to the fullest extent. Furthermore, these obstructions were not financial or managerial but political.

Political regulation of the Health Service

It would be wrong to suggest that all forms of political-macro-level of regulation produced by the reform process were seen by the authorities as antagonistic to their strategic commissioning role. Many of the key strategic targets set by the political centre as part of such initiatives as *Health of the Nation* and a 'primary health care led' NHS are entirely consistent with the wider understanding of health and health care that looks at quality of life rather than absence of disease. The five *Health of the Nation* target areas - heart disease, cancer, mental illness, HIV/AIDS and sexual health, accidents - are essentially programmes of health promotion and disease prevention. At their core are efforts to change behaviour and reduce individual risk factors such as smoking, unhealthy diets and risky sexual practices. The sample authorities on the whole had no problems with *Health of the Nation*. They felt comfortable that they could accommodate the targets within the overall commissioning strategy - with a little modification to suit local circumstances. As one Chief Executive commented:

> Many of the national priorities coincide with local priorities. So there is not a problem. If you look at cancer, renal dialysis, cardiovascular disease, Changing Childbirth, they are very much things that we want to do anyway. So that is nice and easy (Chief Executive, HA F).

Furthermore, more than one director interviewed noted that as the NHS was a *national* health service there should be no concern about meeting national priorities. The only minor caveat from the authorities was that many of the targets involved action that was beyond their role as health authorities or was very long term. Even so, they still felt that it was part of their remit to take the lead in working with other agencies to meet the targets.

A more problematic area is the idea of 'a primary care led' NHS, loosely defined as taking decisions 'as close to patients as possible' (NHSME 1995). For the authorities this presented something of a dilemma. Clearly, if decisions are taken as close to patients as possible then this gives added weight to the opinions of GPs who are the leading primary care practitioners (and to a lesser extent the opinions of other primary care workers). Consulting GPs, as previously noted, was regarded by all the authorities as one of their most important activities. However, despite this ongoing relationship with GPs, both fundholding and non-fundholding, one of the fundamental difficulties for the authorities in operationalising a primary-care led strategy was overcoming their doubts about the true nature of the initiative. This scepticism is illustrated in the following comment by a director of commissioning.

> They have heard a lot of the language about a primary care led NHS and are very, very suspicious. They say, 'well it is fine language. Show us any money. Show us any shift. You are just going to dump on us. You are just going to cut down the beds in the acute and dump the stuff on us and not help us sort it out and not support us with any service network'. So they are very, very suspicious (Director of Commissioning, HA E).

The dilemma for the authorities is that while they did appear to be committed to a primary health care led NHS and shifting resources to meet the new priorities as directed from the centre, at the same time other directives from the Region or the centre had the effect of forcing the authority to act in the opposite direction. Other research has highlighted the this discrepancy felt by providers between rhetoric and action, especially in the non-acute services such as community care (Flynn et al. 1997). Similarly, in their review of purchasing plans and commissioning intentions Klein et al. (1996) point out that despite the fact that health authorities declare that they are committed to shifting resources from the acute sector and into priority areas like mental health, the evidence of real resource commitments showed little change in acute expenditure in the early to mid-1990s. The implication is either that the authorities are being disingenuous and that the scepticism of GPs and some providers is well founded, or that the authorities are committed to change but cannot deliver it for other reasons. The evidence from the sample authorities suggests the latter.

The interview data indicated that many respondents believed they had little room for manoeuvre when faced with demands from the agenda produced at the centre that reflected national priorities. Interestingly the most pessimistic were the Directors of Public Health. The response of one Director of Public Health when asked about the degree to which the authority was constrained by national priorities illustrates the point. As she stated:

> At the moment totally. The first national priority is not to give us any extra money. But having said that we were talking the other day about Health of the Nation, with cancer Calmanisation, with pressure on intensive care beds, with pressures on medical emergency admissions, with pressure on us improving our access to renal services. They are all priorities raining down. I feel like there is no room at all (Director of Public Health, HA C).

Other directors where more sanguine about the situation and pointed to the abolition of the Regional tier of management as a source of extra local flexibility. However, at the same time they pointed out that the region acted as a buffer against direct political pressure. It was also stressed that initiatives such as *Health of the Nation* and a 'primary health care led NHS' did reflect many local priorities and that it was, as noted earlier, a question of placing them in a local context. Even so, all respondents felt that pressure from the centre did constrain action by authorities to meet local needs as they saw them. It could be argued that with the process of commissioning still a relatively novel experience, it was hardly surprising that the centre would be concerned that they should give authorities a sense of direction in what was still uncharted waters. The number of directives might have been considered excessive at one point (see Klein et al. 1996), but this holds out the promise that once the system started to settle down it might be expected that the pressure to conform to national priorities would diminish. That is not to suggest that new priorities would not arise and dominate the agenda. As one Chief Executive described, that is a process which authorities have to contend with already.

> The more interesting things are the ones that blow-up, either because of a continuing problem that appears to have little resolution or because of

> really high profile individual issues... which starts of as a one-off high profile issue, then in the course of the follow-up action appears to identify a major resource issue and there is a very high imperative to resolve that and make sure it doesn't happen again (Chief Executive, HA C).

However, these are not the pressures from the centre that really concerned authorities. The two areas that caused the most problems for authorities and compromised their commissioning remit were waiting lists and most of all the efficiency index.

Commissioning and political imperatives

Taken together, the Health of the Nation initiative and a primary care led NHS are both quintessential 'new public health' programmes. They are concerned with promotion and prevention strategies, emphasising personal responsibility and a self-management of health risk. As such they comprise a coherent package of health reforms that reflects a neo-liberal form of health governance. However, an intrinsic part of health governance is the formal manifestation of governmental power. The difficulty for any government held to account for the stewardship of the NHS is that benefits that accrue from these initiatives are long term. The problem for governments is that even if health does improve according to the set targets and can be attributable to the health service itself, these measures do not reflect the political imperative of demonstrating the 'success' of day-to-day stewardship of the health system. This need to prove effective stewardship leads to direct pressure on a health authority to meet a political set of indicators. As mentioned earlier, it was argued that the abolition of the Regional tier exposed the authority to direct political pressure. As one director commented:

> [And] I think the proximity of the political level now to us as a health authority, rather than being at a distance, has actually made quite a bit of difference because you do tend to get the political imperatives coming straight to Health Authorities, and straight to health authority decision making committees. Where before they tended to be mediated through Regional Health Authorities in a kind of, 'Ooh, what are we all going to do with this', sort of approach. In the sense that it has made things much more immediate and having much more of an impact, and also having the political level imperative attached to it, which is coming

> from the centre, 'you will do this', rather than 'what can we do about this'. That has changed the amount we are able to do on a local level quite a lot I feel in the past 18 months or two years or so (Director of Public Health, HA E).

The two most prominent measures that demonstrate this political dimension are the length of waiting lists and the efficiency index which purports to demonstrate levels of activity in the NHS. Of these the waiting list initiative was seen by most of the respondents to be the least injurious to local priorities. As these two directors observed:

> … But even locally, and even with GPs etc, on the whole, most people would acknowledge that, OK it skewed priorities but, you know, very long waiting list are not defensible really. But what it's done is put in huge amounts of financial pressure into the system because waiting lists are a way of rationing, and always have been (Director of Strategy, HA F).

> The emphasis on the waiting list is linked to the amount of time you've been on a waiting list. So if I've been on a waiting list for 15 months, with a relatively minor condition, you get on the waiting list but you've only been on the waiting list for 6 months, but you're actually in greater need of treatment that I am. Tough!. I'll get it because I've been on longer than you have. And that's because heads will roll if the magic numbers and dates aren't reached. So I think that kind of national policy has an adverse effect (Director of Public Health, HA D).

Overall the impression gained from respondents was not that they considered reducing waiting lists was a 'bad idea', far from it, many agreed with the comments above that long waiting times were indefensible. However, at the same time there was a degree of apprehension that neither the average length of the wait nor the health need of individual patients were taken into account. Instead the key statistic used by politicians to monitor success was the reduction in the *total* numbers of people waiting. As other commentators have pointed out there is a danger that targets based on this simplistic measure are open to misinterpretation. As one former advisor to the Major government commented, 'who cares, when visiting their local supermarket, how many people nationwide might be waiting to go through he checkout in that chain, rather than how quickly they themselves will be out of that store? (Hockley 1998: 2-3). The

convenience for politicians is that waiting list reduction is one problem which can be ameliorated in the short term by spending more money even if in the long run the evidence suggests that ultimately this may be counterproductive. When waiting lists are reduced to lower levels the evidence is that GPs change their referral behaviour correspondingly and increase demand for specialist services by referring patients that they had not previously as a direct result of long waiting list (Henderson et al. 1993). Overall, all the respondents interviewed said that to some extent the effect of prioritising waiting lists reductions did skew local priorities but the additional concern was that they forced the authorities to increase activity, especially in the acute sector.

This pressure to increase activity was the major problem associated with the other measure of activity - the efficiency index. As the name implies the efficiency index seeks to measure activity within the NHS as a proxy for measurement of health gain. In essence the efficiency index is a measure of 'value for money' but does so using a very narrow criterion. Every health authority is given an index target to meet and so has to ensure that Trusts, who actually provide the measured activity, also meet their targets. Without exception, the efficiency index was the topic that elicited the strongest comments from respondents. This was not because the authorities were against a 'value for money' indicator, the concern was about the way the index was measured. Like waiting lists initiatives, it was viewed as having a bias in favour of acute services. The problem for the authorities was that in a health service that produced 'appalling data', the primary currency of the index was based on the monitoring and collection of Finished Consultant Episode or FCE numbers. By their nature, more FCEs are generated within an acute care setting than anywhere else in the service. However, it was forcibly pointed out by many directors, especially Directors of Public Health, that they considered the FCE figures as close to meaningless. The comments of two Directors of Public Health illustrate this:

> I mean FCEs. The biggest way to flannel figures is to look at FCEs. I mean again, if I went into hospital and I was seen by six different consultants, that's six different FCEs. I'm only the one body lying in the one bed and I might have seen the six of them during a two day period. And then we get these wondrous statements that the NHS is seeing more patients that ever. Baloney! Or words to that effect (Director of Public Health, HA D).

> The whole system is actually driven around the number of FCEs. And the increases and the cost releasing efficiency savings, and all the other perverse incentives, all encourage Health Authorities and Trusts to inflate the amount of activity year-on-year. It is stupid system (Director of Public Health, HA E).

For most authorities in the sample meeting the efficiency index was not seen as the problem. The more problematic area was that many authorities wanted to reduce acute activity, as their commissioning intentions had indicated, but could not do so without having to manipulate the efficiency figures. This meant maximising efficiency gains from acute Trusts to compensate for increases in activity elsewhere. There was a general impression that the authorities treated the efficiency index with some disdain because it distracted the authority from their 'proper' role of commissioning. The comments below, from a Chief Executive and a director of purchasing, were representative of the views expressed.

> If when it comes to the contracting process to balance between pound notes, waiting times and efficiency - efficiency was a thing, when you had sorted the other two out, you then see what you are left with. You didn't actually take it massively seriously. Not least of which because we are not in the game of necessarily generating more activity all the time, are we? I didn't think we were actually. We might be in the game of reducing activity in certain areas. So why have a formula that actually encourages you to keep buying more. Doesn't make sense to me (Chief Executive, HA D).

> The one national priority which everybody has kicked against is the efficiency index.... You've got the priorities of things like mental health, continuing care, primary care led NHS. And all those are actually not just not going to generate lots of FCEs but actually should be reducing FCEs. And the efficiency index is so crude and so loaded for acute activity, and not for community activity and even if you changed that shift, the community activity data is pretty raw compared to hospital data. And the whole thing is loaded. But when you talk to Directors of Finance they say, 'Well, it's the only reason we've done better than other public departments with the Treasury over the last 5 years, because each year you've been able to prove you've done more'... It's pathetic. And, you know, every year we are down to what have we got in our back pocket to stuff into the efficiency index. It's just playing the game. It's just feeding the beast. But it takes

> management time and effort away from what we ought to be doing (Director of Purchasing, HA F).

The general feeling was that efficiency indexes, like waiting lists, were part of the political 'game' which had to be entered into by authorities whether they thought it relevant or not. This is an illustration of the relevance of governmentality analysis in the way that regulatory discourses have the power to circumscribe behaviour without 'having first to be interiorised in the people's consciousness' (Foucault 1980: 196).

For those that expressed a opinion there was a view, as one Director of Public Health put it, that 'the politicians have got it every way at the moment'. This was echoed by the comments of other directors. For example:

> Yeah you can measure a FCE but it bears no relationship to patients. But then politically FCEs are marvellous things because the more and more sophisticated we get and the cleverer and cleverer providers get about shifting folks around the system and getting three FCEs for every one patient, the more somebody can stand up in parliament and say 'there is more health care going on than every before', what we do is we count more of it (Director of Commissioning, HA A).

When it comes to comparing micro (providers), meso (strategic purchasers) and macro (political) influence over the reformed health system, it is clear from the last series of comments that purchasing authorities felt constrained by macro-level priorities. However, what was unclear was the degree to which this political dimension was in turn influenced by 'the ability of interest groups (particularly doctors) to manipulate public opinion to their advantage' (Freemantle et al. 1993: 547). This is indeed an important point which will be returned to in the in the next chapter. However, the main finding that stems from the analysis of this macro level of governance is not that formal political control is problematic because it is susceptible to external influence but because it uses an intrinsic calculus of regulatory control that is often antagonistic to other levels of governance. Just as purchasing authorities appear to need to stifle competition to further their own commissioning agenda, then formal political regulation involves the monitoring of variables that seem to be at variance with the commissioning aims of purchasers.

Conclusion

In this chapter a governmentality framework was used to explore the implications for health management practices of the NHS reform process of the late 1980s and early 1990s. It was argued that these reforms reflected a shift from welfare liberalism to a neo-liberal discourse of health governance. Empirical case-study data were presented that explored the rationale of those health service managers within health authorities charged with the specific duty of commissioning health care to meet local health needs. It was argued that this strategic role of commissioning represented a new direction for management within the NHS as part of a new discourse of health governance.

The evidence presented in this chapter leads to the conclusion that the development of the strategic purchasing role within health authorities has produced a very consistent set of management structures, and an understanding of the commissioning remit that seems to reflect a common ideology. Despite some minor differences of emphasis, the interview data suggests that all the purchasing authorities saw it as their duty to make real changes in service provision to meet local health needs. The basis of their activities was the new commissioning role, driven by Public Health concerns. However, it was notable that the internal/quasi-market and the rhetoric of competition - the supposed cornerstone of the reform process - seemed to play only a limited role in fulfilling their commissioning remit. This is exemplified by the comment below from one director of commissioning.

> ...The market language in the NHS, to me, has never been true, because there is no market. The reasons for that, being that you cannot take the ultimate steps which would happen if you were in a true market, of shifting business around to a large extent. Which would mean major closures. In would actually mean Trusts going to the wall now. The way that debate will come will be through specialty configuration, and a different route. It isn't through market forces. And the other thing. We talk about money following patients, the truth of that is that money is very limited that you can't let money follow patients, because in destabilises two large organisations in the local Trusts. And therefore, money actually doesn't follow patients, and Trusts who try to behave in a way that says there is money in the system, if we do things at risk, what they have tended to do is increase

> their own costs and increase the costs of their host purchaser but without attracting the money because it is not in the system (Director of Commissioning, HA E).

As these comments indicate, the commissioning role in effect has to stifle competition in order to function properly. Paradoxically, one of the rationales behind this behaviour by the purchasing authorities was, as stated above, the need to protect Trusts from the destabilising influence of the market. As a consequence, as described earlier, there was little enthusiasm to use contracting in general as a formal expression of a market interaction. Many of the contract relationships appeared to function in more of a symbolic way. Apart from being a technical exercise in operationalising strategic decision making, contracting also reflected a disciplinary process and a means of bringing a degree of stability to the post reform health system. However, despite this expression of commitment to their commissioning remit, all the authorities in the sample felt that they were hampered to some degree by the priorities imposed from the centre. This reinforces the observation made at the end of the last section that micro, meso and macro levels of governance often work against each other even though they are all products of the same neo-liberal form of health governance. This in itself provides a valuable critique of totalising and deterministic discourses of governance. However, this is not to confuse the totalising discourses described by governmentality analysis with governmentality itself.

The fracturing of health governance has major implication for health policy. It is evident that the tension between the macro, meso and micro levels of governance is an inherent part of this form of neo-liberal governance. Therefore, the fact that each 'level' of governance has different, and often conflicting, criteria with which to judge success or failure implies that the de-politicisation of administration is unachievable. The imposition of a market rationality - albeit in the form of a quasi, internal market - in practice does not provide a 'neutral' discourse of governance. The question that now arises is what will be the impact of this fragmented form of governance when authorities, as part of their commissioning activities, are faced with making hard decisions about priorities, (especially when the extra dimension of GP opinion and the purchasing role of fundholders is taken into account)? The rhetoric of change adopted

by authorities was fundamentally a reflection of their new management function. It was unclear how new management structures and new forms of control will be relevant when the decisions to be made about prioritising treatments are essentially moral problems based on value judgements. Whereas the reform process eventually delineated a theoretically coherent set of purchasing principles in terms of management function, it is debatable whether this coherence extends to the production of priorities. If it does not, then one of the central tenets of the commissioning strategy will be undermined. This will be discussed in the next chapter.

Chapter 8

Commissioning for health: hearing the voice of the consumer

Introduction

The previous chapter showed that the market-based, neo-liberal, rationale of the 1990s NHS reforms created a new role for purchasing authorities, that of 'commissioning'. Interview evidence indicates that commissioning, as opposed to the technical function of purchasing and contracting, was characterised by a broader understanding of the concept of health and featured a more strategic management role centred on increasing 'health gain' and meeting local health needs. To aid this new management function a number of novel technologies, such as audit, evidence based medicine (EBM) and notions of clinical effectiveness, were invoked as a means of furthering the commissioning agenda. One of the logical consequences of trying to fulfil this commissioning remit is that it eventually begins to raise questions about the historical patterns of services that have developed as part of NHS provision. In essence, the technologies of commissioning both question the effectiveness of historical patterns of services in meeting 'real' health needs and themselves form the basis of a 'rational' process that can be brought to bear on the problem. However, the effect of rearranging patterns of purchasing to meet this declared health need, means that purchasers are faced with the problematic decision of prioritising services, and those patients that benefit from them, to make best use of available resources. In other words they potentially find themselves in a more intense and explicit rationing debate than previously.

Rationing and priority-setting in general were explored in earlier chapters. However, two points must be reiterated. The first is that in economics terms, health care rationing is inevitable. Where there is no market there is rationing. In the pre-reform NHS, rationing was done implicitly, by clinicians. The post-reform NHS, with its use of a market rationale, potentially makes the decision-making more transparent, and hence, the rationing/priority-setting process becomes *explicit* (Harrison and Wistow 1992). The second point follows on from this. On what basis will the rationing/priority-

setting decisions be made? The technologies described earlier that are implicated in management function (eg audit), basically depend on the notion of effectiveness and scientific medicine to legitimise their use. By themselves they do not form the basis of a rationing agenda. They may form the basis of a decision to purchase, or not to purchase, particular services, but they do not provide a means of comparing services and trading-off marginal benefit against money invested. There are such measures that have been constructed to act as a generic currency of health, the QALY is an example, which incorporate value judgements that act as a quality of life weighting on post treatment outcomes data. But even these proxy measures lack one fundamental ingredient - the legitimacy that comes from reflecting social values, or in a market sense, reflecting consumer values.

To illustrate these points, in the next section there will be a brief exploration of the importance of 'consumerism' and consumer 'empowerment' to neo-liberal forms of governance, and in particular, neo-liberal forms of health governance. This will be followed by a discussion of evidence concerning rationing/priority-setting policies pursued by the sample purchasing authorities. After this examination of priority-setting in action there will be an exploration of the role played in the priority-setting debate by specific groups and institutions, such as GPs, user/carer groups and especially Community Health Councils (CHCs), that mediate particular consumer/patient health concerns to purchasing authorities. The question underlying all these concerns is whether purchasing authorities can fulfil their commissioning remit and take control the priority-setting agenda.

Consumerism and health care

One of the key characteristics of Conservative government policy since 1979 was an almost fetishistic concern with increasing choice and 'empowering' the individual. As Barnes and Prior (1995) observe:

> Set against collectivist ideas of public welfare and the extensive role of government in the provision of services, 'choice' has become one of the clarion calls of the 'new Right' prescriptions for a consumerist form of citizenship and for models of public service which empowers users as

> participants in the market. Consumer choice is the demand-side twin of supply-side competition, as the public services are reshaped through the application of principles of liberal economics (Barnes and Prior 1995: 53).

The basic premise of neo-liberal economics, as noted in other chapters, is that the moral basis of a civil society is founded on the ability of the individual to exercise choice in the pursuance of enlightened self-interest. Therefore, any neo-liberal reform process must be predicated on the imperative of including as much consumer input as possible. It could be argued that ideas of consumerism are not new. Indeed, later in the chapter there will be a description of the role played in the 'reformed' NHS by Community Health Councils. CHCs were specifically created to represent the interests of patients and NHS users to the health authorities in the wake of the 1974 health service reforms. In some ways one can view the creation of the CHCs as a means of making up for the deficiencies in a reform process that took place *within* the institutionalised corporate structure of the NHS, which remained 'producer-oriented rather than consumer-oriented' (Harrison and Pollitt 1994: 37). The reform process in the 1970s (and to some extent reforms in the 80s) did not seek to change the institutional nature of the NHS and extend patients and users control over the Service beyond that exercised at the ballot box. In contrast, the 90s reforms, and initiatives that preceded it like the Griffiths Report (1983), did seek to change the nature of the NHS as an institution, and as part of this transformation placed the needs of the consumer and enhancement of individual choice at the forefront of the reform process.

Choice and empowerment was the mantra that accompanied all the major reform processes instigated by post-1979 Conservative government. It was evident in housing policy, education reform and a host of others. The extension of choice into areas of government activity that informed these reform processes reflected the simple counterfactual embedded deeply in neo-liberal economics - where there is no choice and the consumer is not sovereign there is inefficiency. But more importantly, without individual choice there is no legitimate moral basis for social policy. Therefore, it becomes a moral as well as an economic imperative to 'reform' previous forms of collective welfare. Not only must they be inefficient and thus detrimental to general welfare, they also deny the basic right to choose, to make decisions as informed

individuals. However, in this formula of governance the right to choose also involves certain duties and responsibilities. The most fundamental duty is that citizens have to continuously exercise choice. As Giddens puts it, 'we have no choice but to choose' (Giddens 1991: 81). This leads on to another responsibility already discussed in previous chapters, that of the citizen to choose prudently and not indulge in risky behaviour that would place unnecessary burdens on the state. Taken together it can be seen that within neo-liberal forms of governance choice and risk are intrinsic and inseparable.

However, an obvious difficulty arises when individuals cannot exercise choice directly, for example in circumstances where consumers lack expert knowledge, and choices have to be made on their behalf. In these circumstances a reform process has to find a way of building into the system a means of representing consumer values. The NHS reforms are a prime example of this process at work, involving an ambitious attempt to transform an institution traditionally based on paternalism to one based on consumerism (Klein 1995). The language of NHS reform in the White Paper *Working for Patients* (1989) and the subsequent *NHS and Community Care Act* (1990), had an overtly consumerist dimension. The three key aims of the reform process were; to devolve responsibility; secure value for money; and ' to give patients, wherever they live in the UK better health care and greater choice of the services available (DoH 1989: 3).

Clearly it is one thing to promise choice, the more difficult problem is translating the rhetoric into concrete action. One option pursued by Government was the extension of the *Citizen's Charter* initiative to cover the NHS. The *Patient's Charter*, created in November 1991 and expanded in subsequent years, set out a number of 'rights' for NHS patients, such as limits on various waiting times and basic standards of quality in NHS facilities - but only 'as circumstances and resources allow' (DoH 1991: 6). The spirit of the *Charter* programme, as outlined by the then Prime Minister, John Major, was to 'make consumer views count' in the public sector 'where choice and competition are limited' (1991: 4). However, the *Patient's Charter* with its 'confusing mixture of citizen's rights and customer service standards' (Allsop 1995: 191; Montgomery 1992) does not appear to provide the appropriate mechanism for

extending individual choice over the form of clinical treatment that patients receive. Therefore, the *Patient's Charter* has only a limited function in regulating the provision of health services. However, the *Patient's Charter* was not *the* principal means of representing consumer values within the NHS. The creation of the internal market itself presented alternative ways of including consumers in the purchasing of local health care.

One of the inherent problems in the NHS internal market was that those who exercised a real degree of choice over which treatment and therapies were purchased in the Health Service were generally not the same as those who ultimately receive that treatment. Therefore, a quasi-market in health care in itself is not enough to guarantee the satisfaction of those economic counterfactually conditions that would obtain if a free market in health care were possible. Obviously, counterfactual conditions by definition cannot satisfied. However, in theory, the closer the approximation to the circumstances that would operate under those conditions, the more effective the quasi-market. In effect this is the equivalent of saying that the more the decisions made by purchasers reflect the collective decisions of informed self-interested consumers, the more acceptable, economically and morally, are those purchasing decisions. An obvious method of reflecting local consumer values would be to introduce some kind of democratic accountability into process. Indeed between the 1974 and 1991 reorganisations of the health service, many health authority board members did come from the Local Authorities. However, this was always a very limited form of democracy and there were always questions as to the real influence non-executive members of health authorities had on the decision making process (Allsop 1995).

The 1990s reform process did not take the democratic route. Health authorities were divested of local authority representatives, and, to reflect their new streamlined managerial agency status, those members were replaced by non-executives predominantly from the local business community. Therefore, in order to reflect local consumer values health authorities were given the task of engaging with the local population in order to understand local health needs. As the NHS priorities and planning guidance for 1996/97 states:

Health authorities should have a strategic plan for, and should be engaged in, systematic and continuing communication with local people, representative and voluntary groups (especially Community Health Councils) in respect of the development of local services, purchasing plans, specific health issues and health promotion as appropriate. Particular attention should be paid to addressing the concerns of those with special needs (NHSME 1995).

One important early initiative along these lines was set out in the document *Local Voices: The Views of the Local People in Purchasing for Health* (NHSME 1992). In this document it was suggested:

> If health authorities are to establish a champion of the people role, their decisions should reflect, so far as is practical, what people want, their preferences, their concerns and values. Being responsive to local views will enhance the credibility of health authorities but, more importantly, is likely to result in services which are better suited to local needs and therefore more appropriate (NHSME 1992: 1).

There are a number of points to note in this advice to health authorities . The first is that systematically engaging with the local population is not solely a means of meeting local health needs, it is also a managerial strategy 'of establishing credibility and legitimacy' for the authority (Ranadé 1997: 151). Another point is that combining the purchasing and planning guidance together with the *Local Voices* initiative presents something of a problem for health authorities. To what extent can authorities follow local opinion before it starts to infringe on the health needs of those disadvantaged groups within society? Official encouragement to engage with the local population and reflect local values clearly was not intended as the first step in 'establishing a dictatorship of the uninformed' (Hunter 1993; quoted in Klein et al. 1996: 128). One of themes that emerged from the interview data collected from the sample authorities was a concern, particularly from Directors of Public Health, that in the consultation process some voices may not be heard. For example, one Director of Public Health stated:

> One of my roles is to - I will say things like, 'What about people with learning difficulties? What about people with physical disabilities? And

> what about the classical Public Health underrepresented groups?' And my role is partly to promote the interests of those groups in that debate. Not to say a formal debate, but in the discussion that goes on. So it's a very woolly thing, but that is the reality of it that is how it works (Director of Public Health, HA B).

It was felt that while authorities must reflect local opinion they were not obliged to follow it blindly. Equity had to be balanced with efficiency in order to meet local health needs. The problem is in striking the balance between the two. The logic of the reform process, and the need for individual choice, privileges efficiency over equity. There appears no way of redressing the balance without rejecting the rationale of empowerment and returning to a public services ethos. As Barnes and Prior argue, 'public services exist not just to meet the needs of individuals (and therefore can be legitimised only by aggregate individual choices), but that they exist to meet *public* purposes: they are in part a response to the collective needs of society' (1995: 55; authors' emphasis). In the light of this problem, the next section explores how the sample authorities established their priorities and how much they are informed by the assessment of local needs.

Rationing, priority-setting and health needs assessment

One of the criteria for selecting the authorities in the research sample was the inclusion of a set of well defined priority goals in their purchasing plans or commissioning intentions. Many of the sample authorities ranked these goals in terms of high, medium or low priorities. However, only one authority included in their purchasing plan a detailed list of services that the authority had decided <u>not</u> to purchase as extra contractual referrals (ECRs), except in circumstances of 'overriding clinical need'. The document was very explicit in its description of the services to be excluded. In character it closely resembled the type of selection criteria produced by Berkshire HA that had made front page national news some months earlier (Crail 1995). Indeed the Chief Executive of the sample authority was surprised how little attention their own exclusion list had caused.

In terms of, is the authority content to say that it will no longer, other than in very specific circumstances, use resources to purchase that form of treatment - yes we have done that quite openly and with very much less media interest than elsewhere in the country, which is always something which surprises me... I think it was Berkshire health authority who took a very similar list to our own and got an awful lot of media attention and I half expected my colleague in Berkshire to ring me up and say how the hell did you get away with it.

Taking evidence solely supplied in purchasing plans might lead any researcher to the easy conclusion that this authority, together with a handful of others, were alone in having a strict rationing policy. However, it was clear from discussions with other authorities in the sample that it was far from a unique occurrence. All the other authorities, whether they acknowledged that a formal discussion of exclusions had taken place in the authority or had not, had very similar list of services that they would not purchase except in extreme circumstances. As these Chief Executives described:

One we have actually disinvested in...a very thorough look at plastic surgery. Certain aspects of plastic surgery. We decided we would no longer purchase.... The classic example - there is nothing new here - tattoos acquired in adult life. But there were others, other areas. Unless there were very significant clinical reasons, breast enlargement...Then orthodontics. We have a very strict protocol about what we will and what we won't do in orthodontics. Where do we go next? In Vitro, it's slightly more judgmental. But we do have some, 'so far and no further'. You know, we won't go on trying for ever...again we have tried to say if there are very significant clinical indications to the contrary, we won't apply a blanket ban (Chief Executive, HA F).

We actually agreed a list of services which as a general rule we wouldn't, but we've never said we will never buy something. So there is an escape clause. But there are certain procedure we have identified that we won't invest in and we're starting to have debates now about particular drugs. Should we fund this, should we not fund that?'. So what we've tried to do is, it's a very difficult subject for anyone to handle, for a health authority to handle. So what we actually did was not make it easy for them, but produced a list where there were restrictions in place elsewhere in the country, for a variety of reasons. So they've already had a debate prior to that. And then we've gone on from there (Chief Executive, HA B).

In effect, all the authorities had roughly the same policy with only slight variations in the lists of restricted services. Collating all the lists would produce the same selection of services that have been documented elsewhere (see Redmayne et al 1993; Redmayne 1995; Klein et al 1996). In general, the restriction criteria amounted as much to an ECR policy as a general policy of explicit rationing. Some services were restricted because they were seen to be operating outside orthodox medicine and questions were raised about their benefit to patients. One example was the reluctance of an authority to refer to a private allergy clinic. Another concerned referral to an organisation that provided residential care for those suffering from Post Traumatic Stress Disorder. In these cases the criteria for restriction was lack of evidence of clinical effectiveness. Other services, such as tattoo removal and correction of bat ears in adulthood etc., posed the question of where collective provision ended and individual responsibility began. As the comment below by one director indicates, in some ways these rationing/ECR policies operating at the margins of authority activity, only formalised restrictions that already existed for these treatments.

> Actually the ones that are in here [the Purchasing Plan] in some respects are the fairly easy ones, not that this was easy…And some of them are really social rather than clinical. Because I think there are really two aspects to it. One is whether something is actually clinically effective. And I think if we've got evidence that something is not clinical effective then that is fairly straightforward, we don't do it, we don't fund it. The difficulty is where something is effective but, like gender reassignment or fertility treatment. Is that something we should be using NHS money for? (Director of Service Development, HA C).

The more important question that arises from the use of these rationing/ECR policies is whether they will form a template for future activity, whether the methodologies involved in producing restricted lists are relevant to a more general debate on priorities. The response from the authorities pointed to something of a dilemma. The production of the restricted lists was seen as relatively straightforward with many of the treatments and services, as already indicated, taking place at the boundary of authority activity where restrictions already occurred. However, when questioned about whether the selection criteria used in the creation of restricted lists would

ultimately change historical patterns of core services the replies were more guarded, as the comments of a director of finance testify.

> It ought to. The question is whether we are there or not. Whether we can actually support that from a public health viewpoint, from a health needs viewpoint and a clinical effectiveness viewpoint. Big debate there (Director of Finance, HA E).

It was evident from similar replies that none of the samples authorities had yet engaged in the 'big debate' about priorities. However this reluctance was not the result of a lack of sophistication in their approach to health care. It pointed more to an instinctive pragmatism when faced with the limitations of relying on supposedly more rational ways of doing things. As one Director of Public Health stated:

> I think when it comes to priority debates,... if you are to believe the rhetoric, the totally rational, in terms of Taylorism and scientific rationality around NHS planning, which is nonsense. That you would believe there is this rational process of how many hip operations do we need, where can we get them at the best price and quality, where are we going to contract for them. That sort of stuff. And the other end of it, is the very supply driven, medically dominated process which we have had in the past (Director of Public Health, HA B).

This was echoed in the comments of one Chief Executive:

> Personally I don't think you can convince Joe Public of any rationale around these issues. All I think we can achieve as a purchaser is to try and convince the public that in taking the decision we took we took them against a background of relatively easily understood common sense set of principles. We cannot win the argument in my view because Joe Public, and I'm a Joe Public as well, if something has happened to me or my family then your view of life is significantly changed at that point and I just think it's unrealistic to expect mass numbers to come up with a set of answers which we will feel comfortable with. Possibly. But you know very well that when you are up on the public stand that's not the discussion you will have with individual groups (Chief Executive, HA A).

As one might expect from this comment there was little unprompted talk of QALYs (Quality Adjusted Life Years) or their alternatives in the replies from directors. As one director of finance argued:

> We aren't health economists. We don't have a very easy way of measuring the value of one pound doing that compared with another. Better minds than mine and better minds than most peoples in the health service have struggled all these years with health economics and not one of them have come up with a practical way of measuring the value of a pound. Even QALYs, all of the years in development they are still not deemed to be practical or usable. So now, I don't fool myself that we can do it (Director of Finance, HA A).

Generally, the interview data suggested that purchasing authorities did not feel that they had the tools or the vocabulary necessary to enter into a general priorities debate. Moreover, this reluctance mixed with pragmatism also was carried over to assessing the health needs of the local population.

All the authorities in the sample had an epidemiological approach as the basis of their health needs assessment. However, this was often accompanied by other methodologies such as focus groups and Rapid Appraisal exercises (see Ong and Humphris 1994). But these alternative methodologies were used sparingly and aimed at specific target groups, such as researching the views of women in the *Changing Childbirth* exercise. One reason given was the expense and consumption of management time (see Kelson 1995). The other reason given was that the data that was generated by these methods was often difficult to convert into concrete decisions. This was illustrated by the reflections of one Director of Public Health on a recent Rapid Appraisal in which the authority had been involved.

> Its main dilemma is that it's very difficult to prioritise the stuff you get in the rapid appraisal exercise with the other problems in the district… Now as far as we can tell access to emergency services after hours in that area aren't particularly bad. And certainly in terms of a more formal health needs assessment, it would be very hard to say that's their major health priority but it is certainly something in the perception of the local population they see that as a major issue, access to out of hours services. And it is difficult to address that. It would cost an enormous amount of money to extent out of hours services for the local

> population, and probably not produce very much health benefit. So it produces this sort of, I suppose, dilemma here on a rational point of view, there is not a lot of sense in pursuing that (Director of Public Health, HA F).

Most Authorities in this study were well aware that they were new to the job of canvassing local views. None of the authorities had been involved in setting up arenas where wider health issues could by regularly discussed by members of the public in the form of 'Citizens' Juries' or the like, of the kind that had been created in one or two other authorities in the country (see Maynard 1996; Richardson and Bowie 1995). On the other hand some, authorities had experimented with asking certain groups, mainly user/carer organisations, to participate in an exercise of ranking health priorities. The results were mixed. One of the authorities thought it worth pursuing, others were less sanguine about the whole enterprise. As one Director of Public Health observed:

> I have a lot of reservations about that style of working. I know a lot of people believe that it is one way of involving the public and in getting informed opinions. I question just how informed the opinions are if you simply seat a number of people in a room and ask them what they think about X, Y or Z... We've had some experience of discussion at health authority board level about such things as whether or not we should purchase IVF etc. What should be our views on fertility services. That exposure does not encourage me to go to the big wide world and ask them their opinions. Because it tended to be personal opinions rather that be based on any reading or scientific fact or whatever. Also if you look at the Oregon experiment there are lessons to be learned there because the people who came to the public meetings tended to be predominantly the medical and the nursing professions and others (Director of Public Health, HA D).

However, most directors saw public involvement as a difficult but potentially rewarding exercise. A minority of directors expressed doubts about whether such methodologies could have any real impact in shaping local priorities. One Chief Executive was particularly forthright about the value of public consultation exercises.

> Gimmicks... I think a lot of it is, I'm awfully sorry, I really do. Now [the Director of Public Health] might give you a totally different view. But I've seen the work that some people have done, then you say, 'Well where has that taken you and what has that actually achieved?' And

> they look a little hurt at that point. It is almost as if doing the exercise is cathartic (Chief Executive, HA F).

Taking all these comments together it was clear that the public, or specific groups within the local population, had only a limited impact on the authorities' priority-setting agenda. Therefore, to understand how the agenda is sustained one must look to those groups whose decisions have traditionally shaped the patterns of services within the NHS - historically this has been the preserve of the GP. Given the limits on time and resource, this research could not include direct investigation of GPs' views. However, the interviews with health authority managers addressed the question of the role GPs played in priority setting.

The influence of GPs on priorities

It is one of the defining characteristics of the NHS that GPs have played a dominant role in its development as an institution. GPs traditionally have acted as gatekeepers into practically all the other sections of the health service, the only alternative method of entry being through A&E admission. In some ways it can be argued that this is one of those happy accidents of history. The GP gatekeeper role has been seen as one of the key mechanisms in controlling UK health care costs compared to other countries (OECD 1992). Therefore, because of the structure of the NHS, the aggregate effect of GP decisions to a large degree dictates the pattern of priorities around which health authorities have to allocate resources. In the post-reform era, health authorities have been busy trying to involve GPs in discussions about a wide range of priority and resource allocation issues, such as appropriate ECR activity, encouraging GPs to consider locality funding etc., encouraging them to participate in creating a 'primary care-led NHS' (see previous chapter). In many ways this kind of behaviour by a strategic management could be seen as a classic attempt to control behaviour, and ultimately manage demand. However, there are other factors at work here. GPs can also be viewed as acting like proxy consumers. When they make decisions about treatment for their patients it could be argued that they are acting like the mythical informed consumer. If they can be integrated into the health authority decision making process it would somehow have the effect of legitimising those decisions - a case of

'white coats' instead of 'grey suits'. Survey after survey has shown that when the public is asked which group is to be trusted with defining priorities in health care, clinicians consistently top the poll - by a very wide margin.

Many of the respondents in the survey of health authorities also placed GPs at the forefront of the priorities debate. Some directors, particularly those with responsibility for primary care, saw it as their role to 'make sure that GPs are given a fair crack of the whip' in terms of decisions made about policy and contracts with Trusts. As one director of primary care stated:

> If one of the localities were to say, 'we don't want to place a contract for mental health services with this provider, we want to place the contract with another provider'. And there was a view back here that said, 'well, actually, that's a bit inconvenient, it's messy. We would prefer to contract for all localities with one provider'. I think part of my job is to say, 'hang on a minute. If GPs are asking for that there must be a reason. Let's find out what it is. And if it's valid, let's respect their wishes'. So it is about helping to deliver a primary care led NHS (Director of Primary Care, HA F).

However, at the same time as emphasising the need to include GPs in the decision making process, many directors pointed out the difficulties of slavishly following GP opinion. The basic problem was seen to be the traditional GP culture, ie that it is not part of the GP role to think strategically or work co-operatively with other GPs in the district. The stated underlying reasons for this took two forms. The first was the traditional view of GP activity. As one Director of Public Health stated:

> You've got an individual patient or an individual family sitting across the desk from you. And your sole responsibility then is to look after that individual or the family. The rest of the population doesn't really matter... If you are going to have a primary care outlook then you have got to become population orientated. Even is it your own practice population and not the population of the whole district. Now then that means you have to start thinking about the patients you are not seeing, but should be seeing. And much more about prevention and promoting good health rather than simply preventing disease. Now that is going to need a revolution in thinking. People are going to need much greater support (Director of Public Health, HA D).

The other suggestion was that GPs were not patient-centred but *business*-centred who looked out for their own interests. This applied to non-fundholders as much as fundholding GPs. This view was not exclusive to non-medical directors, several Directors of Public Health voiced the same opinion. This approach to GPs is illustrated by the following comment by a director of strategy:

> GPs aren't patient centred, they're business centred. It's taken me a long time to come to terms with that. Everyone think their GP's prime focus is the best interest of their patients, and I'm not saying that a lot of them aren't extremely dedicated, committed, they want the best. But first and foremost, they are small businessmen. And they have to be able to look for financial gain, sustain their business. And that's what they look to first, even the best of them (Director of Strategy, HA F).

However, the problem that remained for the authority was that if GPs acted in their own interests, or those of the patient, they could not be relied upon to consistently reflect the authority's commissioning role, and may, in certain circumstances, be in conflict with it. Many directors pointed out that authorities had to make priority decisions taking the needs of the district as a whole into consideration. This included making decisions about patients needing specialist treatment that GPs only rarely saw in their surgeries. This situation was described by one Chief Executive:

> Take mental health. What GPs are interested in are what are unkindly called the worried well. We have major issues with forensic psychiatry, the deeply traumatised group. The GPs come into contact with infrequently and so are not so much interested in. That's one. Drug addiction, they would far rather that people just went away. I mean to say that is not a good model of care. So there are conflicts of interest (Chief Executive, HA F).

The general pattern was that authorities were willing to follow the GPs' lead only in certain areas of care where GPs were seen to possess the dominant form of expertise, such as primary care and community services. In other specialist areas different groups were to be incorporated into the commissioning process. One of such group were the users and carers. For example, a Chief Executive argued that:

In areas of chronic care, where learning disabilities is a classic example - people with learning disabilities have it for life. Their parents for example, will know far more about the issue round that than a GP, who may or not have any, or very limited experience. And for those clients I prefer to get a view of the service from them or their reps rather than from any body else (Chief Executive, HA D).

However, like GPs, the relationship between the interests of user/carer groups and the authorities commissioning remit can be problematic. This is discussed in the next section.

User/carer groups: the case of *β*-Interferon and recombinant factor VIII

All the authorities in the sample emphasised their sensitivity to the opinion of users and carers when developing new services or reorganising existing ones. The comments below by a Director of Public Health were typical of the responses from directors.

> I think the other major way of consulting with people is though the service reviews and making sure that the local voluntary groups, the users groups, the carers groups are involved because it is much more real when you are talking about the needs of people with disabilities, or whatever, there is something crisp to catch hold on rather than nebulous global health issues (Director of Public Health, HA C).

For authorities, the obvious advantage of working with such groups was that they directly represented consumer/patient interests or were the consumers themselves. However, caution was also expressed that many of the groups were partisan by nature, and this needed to be taken into consideration when including them in service development discussions. Another problem with these groups, it was suggested, was that difficulties would arise when there existed different factions within the same area of concern, all competing for attention. This is reflected in the observations of one director of service development:

> I think what we would do is where we are looking for representation and input, in terms of people sitting in groups and participating in working groups, we would actually ask the CVS [Council for

Voluntary Services] for representatives rather than going straight to any particular group because there is always the danger of one group not being seen as representative by other groups in the same field. So it is best to go through the CVS to ask for a general representation rather than go to any particular organisation. When it actually comes to consulting, then yes, we would involve all the relevant organisations (Director of Service Development, HA C).

Apart from service development it was clear from the interview data that user/carer groups had other ways to influence the priority-setting debate. One of the examples most often cited by directors of user/carer influence was in the introduction new, and many times unproven, drug therapies. To illustrate the dilemma faced by directors in funding such treatments, there will be a brief discussion of two such novel therapies - β-Interferon in the treatment of Multiple Sclerosis and recombinant factor VIII used in the treatment of haemophilia. The debate about the introduction of these new and usually very expensive drug therapies has been documented elsewhere (for example Freemantle and Harrison 1993, on Interleukin-2). The case of β-Interferon and recombinant factor VIII represent just two of a number of new high profile drug treatments that have been developed by drug companies either as a means of treating previously intractable conditions or are marketed as safer and more effective treatments than established drug regimes. The controversy surrounding both these drug treatments highlights a number of problems for health authorities seeking to retain control of the their own priority setting agenda. This becomes even more difficult when there is a difference of opinion between medical professionals and user/carer groups over the efficacy of such treatments.

The case of β-Interferon illustrates some of the difficulties faced by health authorities in coping with new drugs designed to treat diseases for which there were no drug treatments. β-Interferon is the first new product to treat (but not cure) the chronic disease of Multiple Sclerosis (MS), especially for patients with the relapse-remitting form of the disease and without significant disability. The drug has the effect of reducing the frequency of relapses as the disease process progresses. For this reason β-Interferon has been described as a 'drug company's dream-ticket', in that MS is incurable, relatively common and that β-Interferon is fairly expensive (Rous et al. 1996: 1195). The cost works out at approximately £10,000 per patient per year or

£33,000 per relapse avoided (Richards 1996: 1159). It has been estimated that if all the patients in the UK with relapse-remitting MS (45% of the total) were to the treated with β-Interferon then the total cost may be as much as £380m per annum - equivalent to 10% of the total drugs bill (see New 1996).

Clearly, uncontrolled prescribing of β-Interferon would have had a major impact on health authority spending. In recognition of this a guidance letter was produced by the NHS Executive on prescribing the drug (NHSE EL(95)97). The drug would only be available through consultants at regional centres and each authority - in collaboration with the MS Society - would have to devise a protocol for its use that would set in place patient selection criteria. However, what worried the authorities in the sample was not the problems associated with protocol production but that β-Interferon had set a precedent for the introduction of <u>other</u> contentious drug therapies. The most problematic aspect was the absence of debate about the impact these drugs would have on the allocation of resources to meet other more pressing local priorities. This concern is illustrated by the response from a Director of Public Health.

> Take drugs. There are two decision. One is in principle is this a drug that the NHS should be providing? The second decision is, if it should be provided, for whom and under what circumstances? The first of those decisions on β-Interferon was taken by default - 'β-Interferon is a good thing' - from on high. The problem then was managing the introduction and that was about protocols and so on, and health authorities putting aside development money if they could. That process is starting to be used as a template for other drugs and other technologies. I'm a little concerned about that, because if I am straightaway into a debate about how do I manage the introduction of things, and for whom should it be available. It begs the question of whether it should be in the first place and I don't think there is yet a mechanism for asking those questions, that initial question (Director of Public Health, HA B).

This concern was echoed in other authorities. As Rous et al. point out:

> Purchasers were unable to decline funding for a marginally effective drug and thereby undertake explicit rationing. To ensure prescribing was within the guidelines, a vast communication network had to be sustained with managers, general practitioners, neurologists, the

> Multiple Sclerosis Society, and professional advisers in all the purchasing authorities. The workload involved was considerable (Rous et al. 1996: 1196).

However, the lack of debate about purchasing at authority level did not prevent a lively debate within the medical profession from developing. The medical evidence about *β*-Interferon and its long-term effectiveness was disputed by several senior neurologists. It was suggested by that *β*-Interferon should not be made widely available and that resources would be better spent on other kinds of support for MS sufferers (McDonald 1995; also see Drug Therapeutics 1996). It was apparent that some of those who opposed the introduction of *β*-Interferon felt that the proper evaluation procedures had not been adhered to and that non-clinical values had prevailed. As one consultant public health physician noted:

> … it would appear that a small number of enthusiastic neurologists and an active patient lobby has dictated policy at a national level. It is a very high risk strategy to introduce this drug into routine use on the basis of a single, small clinical trial and accelerated licensing process, especially when the lost opportunities represented by costs are so great (Richards 1996: 1159).

In response to such claims the chief executive of the MS Society emphasised the 'responsible way the MS Society [had] sought to work with those managing this complex situation' (Cardy 1997: 600). Furthermore, he stated:

> The MS Society has worked hard to ensure access to authoritative information and to reduce expectations. As a result, patients in Britain have not made a stampede for interferon beta (ibid.)

On the whole, the experience of sample authorities reinforced this sentiment and expressed satisfaction with the production of the protocol. They were no reported serious problems with the MS Society and, in general, it was stated that they had acted 'responsibly' in the protocol discussions. However, one director suggested that they had unrealistic expectations of the effectiveness of the drug, and that the MS Society thought *β*-Interferon was 'the best thing since sliced bread'.

At the core of the controversy over the introduction of β-Interferon is the question of effectiveness. It was clear one of the key elements in the dispute between representatives of MS sufferers and the medical profession about the usefulness of the drug was the different values each group attached to patients' state of health. For some neurologists, the important factor in opposing the introduction of β-Interferon was that it 'has no significant effect on the development of disease in multiple sclerosis' (Harvey 1996: 297). The narrowness of this view based on clinical indicators and ultimate end-states for patients was starkly at odds with the views of many patients, where the reduction in frequency in relapse is a justifiable goal in itself. As one chairman of a local MS group asserted in a letter the BMJ:

> Multiple sclerosis is a distressing, humiliating, and often long drawn out disease with no cure. For this reason, quality of life, for patients and their families, is paramount. A drug that can reduce the frequency and severity of relapses, whether or not it diminishes the progress of the disease, will be of great clinical benefit to many patients, improving their situation physically, psychologically, and socially. Surely happiness, feeling better, and increased health have great value (Burnfield 1997: 600).

In this respect, the quality of life aspect for MS suffers is of equal value to that accorded to preventing the disease from progressing. Therefore, it could be argued that in their own terms, many MS sufferers view the use of β-Interferon as a legitimate use of resources. The potential improvement in the quality of life for suffers is in itself justification enough. However, in terms of clinical measures of post-treatment outcomes based on changes in the physical health status of the patient, these quality of life values were not readily amenable to calculation as part of a general disability measure. Therefore, it is apparent that when there are conflicting, but equally valid ways of conceptualising outcomes, then the measurement of effectiveness will be compromised. And if effectiveness is the criterion which informs the priority-setting debate then the transparency and explicitness of the debate will also be compromised.

The example of β-Interferon illustrates the difficulties that even a controlled introduction of a new drug had for authorities trying to prioritise services. These difficulties were compounded for drugs that found their way onto the agenda with little

or no forward planning. Such a drug is recombinant factor VIII. Like β-Interferon, recombinant factor VIII was a new expensive drug, in this instance to treat haemophilia. However, unlike β-Interferon, there was already a similar, well established drug on the market, a heat treated factor VIII, which was much cheaper and regarded by many as equally effective. The problem with this form of factor VIII was the perception of a small residual danger of infection from HIV and hepatitis viruses that may not have been removed in the purification process. The genetically engineered recombinant factor VIII presented no such dangers. In effect this represented the classic problem trading-off risk against cost. For the authorities, the result of this calculation was the decision not to purchase the new form of factor VIII. However, for many parents and user groups the risks were too great and this led to pressure on consultants to prescribe recombinant factor VIII. Unfortunately for some of the sample authorities, treatment had been approved on the basis of a simple ECR request and so had slipped through the system without scrutiny. This was common knowledge within other authorities, as the observations of a neighbouring authority's Chief Executive demonstrated:

> My understanding is not only were the consultants saying that this drug is suitable for this person, they were saying another reason for prescribing it was if the parents believe there is a danger - so they were redefining what clinical effectiveness meant. Because if you take the drug as it stands, there are question marks over the drug. Well, it is not proven that it is any better than the high purity, but the consultant was taking it further because the parents were saying they believe it is was, it should be prescribed. And you can go on like that for numerous drugs. And if you take the example, you had a haemophiliac child, you had haemophilia which is an emotive issue, you've got children which is an emotive issue. Parents, consultants, whatever, on the one hand. So everybody says 'Yes, vote for that drug'. On the other hand at the same time we have a drug which is now being released for people suffering for HIV and AIDS. It's less emotive in terms of it being prescribed, but that drug has been proved to be more effective. Not which one do you go for. The one that Joe Public would react to first and foremost, it's a child. Or what? And actually the decision we've made is, we've said no to recombinant factor VIII, and yes to the HIV/AIDS drug. And that's purely on clinical effectiveness grounds (Chief Executive, HA B).

The consequence of this uncontrolled prescription of the new form of factor VIII was that when the authorities became aware of the situation, some found themselves in the

difficult position of having some haemophiliacs on the drug and others in effect being denied it. As one director put it:

> I feel very sorry for the Authorities that have got one or two [children on recombinant factor VIII]. Because they didn't know they had them, until it happened. That's put them in a really difficult position. I mean, I said yesterday before the public authority, that we are extremely lucky that we are not one of the districts with one or two on it. Then you are faced with the decision of do they come off it, or we accept that the clinicians have taken this decision, but we're not having anymore. And I think we would probably had to go with that one, because to force someone off a treatment once it's offered. I think that's why, if you like, I think it is extremely important that the Trusts managerially are keyed into what their clinicians are doing. Because that should never have been allowed to happen (Director of Strategy, HA F).

As a result of their situation the authorities involved were for a time the focus of intense local media scrutiny, often of an emotive kind. In the end it was only resolved by intervention from the centre and the production of national guidance.

Again, as with β-Interferon, there was a clear difference in the value judgements involved in estimating the efficacy of recombinant factor VIII. For haemophilia sufferers recent history had shown the inherent dangers of using clotting factors derived from blood products. Contamination of products with HIV and hepatitis viruses had led to many sufferers becoming infected and being further disabled or dying as a result. Therefore, it is understandable that perceptions and acceptance of risk were much different for sufferers. Even the theoretical residual risk associated with the cheaper purified factor VIII was thought by many to be unacceptable.

The clear implication of both β-Interferon and recombinant factor VIII is that, like GPs in the previous section, the views of user/carer groups cannot be directly incorporated into health authority commissioning plans. The disparate and partisan nature of the groups will often result conflict with the strategic aims of commissioning. Health authorities are compelled by their remit to allocate resources to meet the health needs of the local population as a whole. The demands of particular groups for more resources have to be balanced against the equally legitimate claims of other groups and

the needs of the local population. However, the examples of β-Interferon and recombinant factor VIII illustrate that this balancing act may prove problematic for commissioning health authorities. The lack of an explicit debate about priorities indicates that there is no language of prioritisation in which competing claims for resources can be discussed rationally and without emotion. Moreover, the use of governmentality analysis strongly indicates that the failure of such a language to evolve appears to be a function of the fractured nature of governance rather that a lack of will on the part of health care commissioners.

The role of CHCs

One of the key features of the recombinant factor VIII affair was that the controversy spilled out of the narrow confines of specific pressure group activity and began to be championed by the local Community Health Councils in their role of health 'watchdog'. The rest of the chapter will therefore focus on CHCs and their relationship with health authorities. The evidence to be presented is based on semi-structured interviews (n=9), conducted between March and July 1997 with a selection of Chief Officers of CHC that operated in the districts of the sample authorities. The average duration of interviews was 45 minutes. For the purposes of identification each CHC has been given a code letter from A to I (please note these code letters do <u>not</u> correspond to those given to sample authorities, in order to prevent identification).

As noted above, CHCs were specifically created in 1974 to represent the interests of patients to health authorities and provide for 'the expression of local opinion' (DHSS 1972). The council of the CHC is composed of members appointed by the Regional health authority, usually half are nominated by the local authority, a third nominated from the voluntary sector and the remainder nominated by the Region itself. In total this comprises about 18-24 members. Many of the CHCs in this study sample also had co-opted members that acted as a reserve to maintain numbers if necessary. In addition to the members there was a small number of paid staff which included the Chief Officer. It is the role of the Chief Officer to co-ordinate general Council activity and to provide confidential support in the complaints procedure. The CHC has two main roles; monitoring the operation of the local health service, making recommendations

for improvement if necessary; and to be the source of information to public on health matters. To meet these aims the CHC has a set of limited statutory powers, these include the right to consultation about major service changes, the right to ask for information from health authorities, including the right to observe at authority public meetings. In addition the CHC has a right of inspection of certain NHS provider organisations, but this does not extend to GP premises or the automatic right of inspection of non-NHS providers. These limited powers do not include the monitoring of contract negotiations or participation in the audit process. This was despite a plea in 1989 by the Association of Community Health Councils for England and Wales (ACHCEW) for formal involvement in audit. This was denied on the ground that audit was a professional activity and not within the CHC remit of monitoring quality (Harrison and Pollitt 1994).

Taken together with low levels of funding, many commentators have argued that these limited powers to shape local provision health services and weak powers of inspection of providers amount to a serious handicap to CHC effectiveness (Allsop 1995; Lupton et al. 1995). Despite their weak position, the CHCs have survived a series of NHS reforms more or less intact, notwithstanding regular calls for CHCs to be abolished (DHSS 1979), be reformed themselves (Butler 1998), or become absorbed into health authority management (Insight Report 1996). Indeed others have pointed out that the 1990s reforms opened new opportunities for CHCs (ACHCEW 1992; Barnes and Cox 1997). Moreover, the priorities and purchasing guidance (1996/97) referred to earlier in the chapter, specifically singles out CHCs as organisations that have to be part of a consultation process with local people. However, there is one major difference in the circumstances that CHCs now find themselves in compared to past experience. They are now faced with a rival as 'champion of people', namely the health authorities themselves.

Health Authority or CHC: the people's champion?

Significantly, the dominant view amongst those Chief Officers interviewed in this study was that the health authorities were *not* the people's champion. As one Chief Officer stated:

I certainly don't see it that way... they are not the 'champion of the people', that's a very different role because that's much more of a pure role and that's where the CHC has a much more purer, independent ability to act. Because the health authority has to take into account other agendas. They have to take into account the consultants, the managers' view, the financial view, etc.. And we as a CHC can take a purely patient oriented view of services of possible changes and possible reconfigurations. And I think that is the difference (Chief Officer, CHC G).

Moreover, most CHC chief officers contrasted the many years of CHC experience of canvassing local patient/user use with the health authorities' perceived lack of experience.

You've got a responsibility to get an informed view... What alternatives are there? And that is why I say that it's not a one off. It is a very sophisticated process and I don't think health authorities, and Trusts, have really got to grips with it. They think they can do it, but they are very poor at it... [w]e've been doing it for 21 years, well 23 years now, since 1974. That is something that we have been doing (Chief Officer, CHC F).

If [the health authority] had to suddenly start up doing things like Citizen's Juries or patient's councils, or whatever, it would be extra work that's so different from what they are doing now. But we are half way there, if you will (Chief Officer, CHC H).

... the health authority... they're not good at consultation. Classic example of their public consultation was to arrange a public meeting at a hotel, which has got an hourly bus service, upstairs, for young mums at lunch time. And the second meeting aimed at mums and young women was in the evening time when you are trying to put your kids to bed, you know. And then they wonder why they didn't get anybody coming (Chief Officer, CHC B).

But the irony was that CHCs and health authorities, shaped by differing conceptions of consumerism, should have very similar difficulties with representativeness. It has to be acknowledged that CHCs also suffer from a similar democratic deficit as befalls health authorities. Perhaps it is an indication of the sensitivity to this issue that most CHCs

were quick to pick up on a question about the background of members and interpret it in the same manner. For example:

> What you want to know is are they middle class. And the answer is yes, 90% they are… mostly middle class, yes (Chief Officer, CHC A).

Interview responses indicated that for the bulk of Chief Officers this was only a minor deficiency. The membership itself might not be representative of the local population in which the CHC was situated, its patch, but a kind of direct representativeness could be manufactured through Regional appointments that reflected the geographical and ethnic composition of the area. As one Chief Officer stated;

> … I mean it doesn't say anywhere in statute that [the CHC] has to represent the population in microcosm or whatever... They certainly aim to have a bias in favour of what you would call the vulnerable groups, or minority groups, whatever you want to call them. And I think, and I haven't really had a lot of thinking time on that one, I think that is a good thing. We do try to some degree to make it fairly representative in microcosm. I'm not sure it is necessary (Chief Officer, CHC I).

For most CHCs this was not seen as an insurmountable problem because, like the health authorities, they saw representativeness as emanating from the *process* of eliciting local patient/user views, and from the direct involvement of CHC members in local user/carer group.

> The representativeness comes from the work. I think it should come more from the members. But I would say, you know, if you divided up a pie, 10-15% works through the members (Chief Officer, CHC I).

However, most of the CHC Chief Officers made the distinction between representing the local community and representing the <u>interests</u> of the local community. With varying degrees of enthusiasm, they envisage that they might be placed in a position of supporting very contentious health authority decisions - ie the rationalisation of local acute units - that they know instinctively would not be the consensus view of the local population, but which the CHC supports because it saw the change as being in the best interests of the local population. In effect, they endorsed the decision because they

believe it would have been the decision the public would arrive at if they were as well informed as the members of the CHC.

> … I mean it sounds superior to say it, very often we are in the fortunate position of having access to better information that the general public, whoever that might be. And we have to use that information to decide on our priorities and what we are going to do about them, and take a view about what is the best interests of our community. And that is a different issue. And I think that is much more along the lines of how CHCs do work, the community's interests rather than being their representatives. And sure maybe that's as good as we can hope for, maybe that's OK (Chief Officer, CHC C).

But above all, the CHC did not want to run the risk of being seen as agents of the health authority, or acting as their mouthpiece.

> … And of course [we] run risks of losing credibility and respect and being seen as a local voice. You know, I think there is a fine line they tread between of being seen to be the 'Champion of the people' or the lap dog of the Authorities (Chief Officer, CHC C).

Nevertheless, this kind of thinking did seem to have its limits, and did not appear to extend to putting district level patient interests above the interests of their own local patch. Only one CHC Chief Officer suggested that that this was part of their CHC's policy.

> The CHCs might differ in the view of what is in the interests of patients but we wouldn't be parochial and say [our patch] is doing great out of this, that's fantastic, we'll support that, if it meant it severely undermined a service or… could severely undermine a service in a neighbouring hospital or could even undermine the hospital… In fact I've been criticised for looking at the wider interest and not responding to what local people say should happen, even if it is at the expense of somebody else. And I've checked it out with members and that is a clear position for [our] CHC, and I know that conflicts with the way some people see the job (Chief Officer, CHC G).

Ideas of pan-CHC alliances to counterbalance health authority influence did not seem to be evident, quite the opposite in fact. It was not a case of 'my patch, right or

wrong', but that was nearer the mark than assuming that CHCs within a district operate on a strategic, district level of thinking.

> .... Sometimes I get the sense that health authorities use us against each other. And they sort of get surprised when we say all power to so-and-so because she [another Chief Officer] is in charge of her district. It's her job to get the best services for her district but I will always fight my corner here....(Chief Officer, CHC I).

Even so, all the CHCs saw themselves as being more representative of the local population than their own health authorities. Several of the Chief Officers drew attention to the health authority's perceived remoteness from the local population, both socially but also physically. Phrases such as 'in their Ivory Tower', 'distancing themselves' were not uncommon. The feelings of many CHCs are summed up below;

> ... perhaps it's the location [of the authority offices] - the middle of nowhere. Which we have complained about and said how do you expect the public to come to your board meetings unless they have got a car? 'Well there is a bus service'. Yes, but it's like three quarters of a mile from the bus stop. And it's not a very user friendly building... (Chief Officer, CHC B).

Importantly, the health authority respondents, of those that expressed an opinion, tended to agree that the CHCs, despite being a form of quango themselves, were more representative of the local population than the health authority itself.

> ... CHCs are slightly more effective [as champion of the patient], but health authorities are quangos. They are unrepresentative and there are tensions which exist in health authorities between the executives and the non-executives. But the non-executives in the past might have included elected councillors and people from the Local Authority. And now a lot of people are there because of their business interests, because of their skills in management. And so health authorities have some difficulty in getting political legitimacy from the population they are actually serving (Director of Public Health, HA E).

But at the same time the health authority respondents were less than flattering about the quality of work that the CHCs produced from their independent consultations with

the local populace. It was described as 'without scientific rigour... very poor market research... health authorities and Trusts don't have to act on them because of the way in which they have been collected'. Those who expressed an opinion seemed to suggest that the CHCs have potential but this, in general, can only be realised when working with the health authority using the 'correct' methodologies as supplied by the authority. The CHC was seen as at its most useful when disseminating health authority information so that the local community could appreciate the health authority positions on various issues.

CHC influence on the priorities debate

It can be gauged from the above remarks that in general, (5 out of 6 health authorities and a majority of the directors interviewed) thought that the CHCs were marginal to authority activities, especially in the production of the annual Purchasing Plan and general strategic thinking - CHCs were 'recipients rather than shapers and influencers'. This is the conclusion drawn by most CHC respondents. As one Chief Officer stated when asked about the CHC's influence on changing health authority priorities, 'If the health authority was a thousand miles long, about half an inch.[laughs] Not a lot... one gets the impression time and time again that they have already decided what they are going to do and the CHC gets invited to sort of twiddle around the edges' (Chief Officer, CHC C). Even some of those Authorities which attested to good working relations with CHCs attributed this to the fact that 'they don't cause us a problem'. On the whole, there seemed to be little enthusiasm from health authorities to include CHCs in their discussions. The CHC was 'still a distant, kept at arms length, organisation.' (health authority director). This echoes previous research (Appleby 1992; Dunham and Smith 1993) At the most extreme, some of the health authority respondents did little to hide their views that CHCs were, in their experience, politically motivated and personality driven organisations. A similar point was made by health authorities in previous studies (see Harrison and Wistow 1992).

> ... But they really should be our best source of representing the public, what they want. They are very often one of the worst sources for that in that they represent the particular political prejudice of the people

> involved and very little in terms of the vast majority of the public (Chief Executive, HA F).

However, it was evident that Chief Officers themselves did not regard their CHCs as having a political agenda, especially a party political agenda, except in the sense that many of the causes advocated by CHCs had a political dimension. When it came to involvement in CHC activities of political appointees from local authorities, the majority of the Chief Officers voiced some disappointment at the level of commitment shown. This is illustrated by the comments of the Chief Officers of CHC F and CHC D:

> I think Local Authorities have not taken on board the importance of the CHCs. You'll find that Local Authorities complain bitterly about the lack of representation within the NHS. And will rail against the fact that they lost representation to Health Authority boards and that they don't have automatic representation on Trust boards, although they are not excluded. And yet they do nothing about, or very little about, their nominations to the CHCs, which are, you might say, almost the last bastion for true democracy and representation within the NHS. And I find it strange that they complain on the one hand but don't do anything to remedy the situation on the other hand. They don't take hold of the opportunity (Chief Officer of CHC F).

> If you look down on the list of the ones that don't turn up on a regular basis - you feel they are not committed to the CHC - they are probably the Local Authority representatives. We've got more actual councillors now. Of course they don't have to appoint councillors, they can appoint anyone they want. In some ways you need to have councillors because they a representative background, don't they. They are representing the community. But I suppose again, their first loyalty is to the Borough Council, and the first call on their time. So they are quite poor attenders really (Chief Officer of CHC D).

Additional antagonisms with health authorities often occurred around differences of interpretation in the meaning of the terms 'participation' and 'consultation' (see Ham 1980). Several CHCs noted that they believed that their health authority used these terms interchangeably.

I mean you often get, 'well it's in the Purchaser Plan', when we get into a situation where you challenge something that they have implemented, 'it's in the Purchaser Plan'. And I've had a letter this morning where we have challenged something and I've got, 'it's been discussed with you, the changes in this service'. And I can't remember having any formal discussions on the introduction, on the changes and the development of this service (Chief Officer, CHC B).

Yes we do [have much influence on the Purchasing Plan]. We're always sent... No, no why am I not honest on this. We got the contracting document and it was completely and utterly useless, apart from the fact that we had three days in which to comment. Which meant I was the only person who had the time to look through it. Didn't really much matter because there really was so little we could comment on usefully anyway. It just said to be decided or as so and so. It was absolutely, well, I felt it was a formality. And I'm not sure they've got to grips with that properly themselves (Chief Officer, CHC A).

Another area of conflict stemmed from confused notions of consultation and responsibility, especially important when CHCs were encouraged from above to participate in strategic discussions (Dorrell 1992). The CHCs expected to be included in these discussions, but at the same time they reserve the right to distance themselves from any decisions in order to preserve their own autonomy and independence. For example:

> The stance that we've taken is that we wish to be in on strategic level discussions, planning discussions, putting forward the views of users and the community, but we will not sign up to the decision... But when it actually comes to making the decision we say that isn't ours. So in other words we don't want a voting right on the decision. Then we would be captured because, quite rightly, the health authority would say, 'You signed up to this. You were instrumental in making the decision. Now you are challenging it'. No, well we've given you all the information, we've said what we needed to say, you've considered it, this is the decision *you've* reached. We can agree with it on behalf of the best interests of the community, but we might challenge it on behalf of an individual (Chief Officer, CHC F).

In many instances CHC representatives were active participants in the groups that decide the structure of the guidelines for restrictive treatments. However again the CHCs reserved the right not to be bound by any decisions, and would challenge them if

necessary by advocating the cases of those individuals denied treatments by the decisions. It was not their job to set priorities, it was asserted, but make sure that individuals and certain groups are not marginalised in order preserve a degree of equity in the health system. The complaints procedure becomes all important in giving disadvantaged constituencies a voice - such as transsexuals and the restriction placed on gender reassignment - and making sure that the health authority can justify their decisions.

> I think we will be involved in the rationing debate... Because it is clearly there, and it's clearly going to be on the agenda. And we wouldn't want to be involved in developing an Oregon style list of services because the exceptions are always there, and the CHC would be on a hiding to nothing to approve a list. So very much *not* wanting to get involved in approving decisions but definitely wanting to be involved in the debate. And ensuring the debate is carried through appropriately and ensuring there has been, yes, consultation... and they've really thought it through before they have come to a decisions. But also pushing that it shouldn't be a local health authority agenda, it should be a national agenda (Chief Officer, CHC G).

> And really I don't want to get involved in making the decisions [about priorities], what I want to get involved in as we are, if the people want to appeal against this what is the procedure and can we help them through that. I think that is much more our role. We shouldn't be making the decisions, they're paid to do that not us... I'm sure we should have input in the debate but not the decisions... It's not our role to make decisions. To pass through the patient's point of view, which we do have , gratuitously and by seeking it out. To pass it through because that's the knowledge they need to make the decisions (Chief Officer, CHC A).

Many directors interviewed accepted the position that the CHCs must at some point in the discussion distance themselves from the process to preserve their independence. But other Directors interpreted it as whimsical and capricious behaviour, a sign that that CHCs are not serious players in the debate. Thus:

> ... they see their role as being the promoter for better services... and I don't mind this, but they don't see their role as the ones that have to say, 'Well OK, there are priorities so we'll prioritise. It's our duty to prioritise'. There's a bit about, 'Power without responsibility is the

> prerogative of a…', [Interviewer: 'A harlot?'],…Ah now, I didn't say that, you said that. (Chief Executive, HA D).

> You're aberrant… they get fed up with our 'irresponsibility' at times (Chief Officer, CHC G).

Therefore, because of the importance of GPs, health authorities may not feel they need to seek a form of legitimacy by co-opting CHCs into decision making. Although it was evident that one or two of the Authorities in this study did consider the local CHCs as 'stakeholders' in the process, most health authorities appeared not to need or want to involve CHC much beyond the statutory requirements, except in specific circumstances, such as the reorganisation or introduction of new services.

Conclusion

The purpose of the chapter was to present an exploration of the importance of the concepts of 'consumerism' and consumer 'empowerment' to neo-liberal forms of health governance. Of particular interest was the way in which these concepts informed health authority commissioning activity and the production of rationing/priority-setting policies. To illustrate this discussion there was an examination of the role played in the priority-setting debate by three specific groups and institutions. They were GPs, user/carer groups and Community Health Councils (CHCs). Each of which could legitimately be seen to represent the interests of the health care consumer and reflect some form of health need within the community.

Overall, the evidence presented in this chapter indicates that public opinion had little direct impact on health authority activity or the priority setting agenda. This was despite the new role for authorities as 'champion of the people'. It was clear that the opinions of GPs continued to dominate the purchasing agenda. This appeared to be for two reasons. Firstly because they personified a form of primary care level expertise and secondly, that when acting in their patient's best interests they behaved like 'proxy consumers'. However, GPs could not be relied upon to act strategically when deciding on treatments for their patients. This problem was repeated when authorities

incorporated other groups, such as user/care representatives, into the strategic commissioning process. The case of β-Interferon and recombinant factor VII illustrated this point. The evidence suggested that these groups were useful to authorities because they were able to bring an unmediated understanding of user and carer health needs to commissioning. However, user/carer involvement in commissioning was treated with suspicion by some directors because of the fragmented and partisan nature of the groups. Even so, it was evident that a number of the sample authorities considered user/carer groups to have more influence over the commissioning process than the official consumer representatives in the district, the Community Health Councils.

In investigating the role of CHC activity, it is evident that although this study was not as extensive as other recent pieces of research into health authority/CHC relationships (eg Lupton et al. 1995), it is broadly consistent with their findings. The key findings about the concept of representativeness indicated that CHCs saw themselves as being more representative of the local population than their own health authorities. This sentiment was one with which the health authority respondents tended to agree. However, five out of six of the health authorities, and a majority of the directors interviewed, thought that the CHCs were marginal to their activities, especially in the production of the annual Purchasing Plan and general strategic thinking. This presents a picture of CHCs being marginalised by their health authorities, and despite the occasional victory, having little impact on policy making. Although some of the health authorities did seek to include (or co-opt) CHC representatives in decision making processes, they still felt that, in general, CHCs had little to offer at present. Furthermore, health authorities in the study were increasingly interested in engaging with other voluntary sector organisations and user groups, together with, and sometimes instead of, the CHCs. When it came to the thorny issue of rationing and priority-setting, most CHCs felt that they should be included in rationing debates but reserved the right not to be bound by any decisions so as to preserve their own independence. The CHC/health authority relationship has historically been seen as problematic but with both organisations now striving to become more professional, they are increasingly contesting the same ground. The CHCs, the weakest of the two by far, have been placed in an unenviable position. They can remain as they are and risk being further marginalised and the voice of the consumer being lost, or become part of

the health authority's strategic planning process and risk losing their own independence.

From the evidence presented in this chapter it can be argued strongly that purchasing authorities lacked the means or vocabulary to embark on a full scale priorities debate. However, it has to be emphasised that this was not because of any lack of enthusiasm. All the authorities had embarked on a limited process of formulating local priorities, but this was mostly at the margins of authority activity, ie ECRs, which had little impact on overall priority arrangements. The question posed was whether these small scale attempts to bring some king of 'rationality' to the priorities debate could be scaled up to become the basis of a 'big debate' on priorities. This research shows that this did not seem to be happening. On the one hand, authorities seemed to be daunted by the enormity and complexity of devising global strategies. The response was to fall back on to a form of pragmatic incrementalism, aided by the use of managerial technologies such as audit and effectiveness criteria. On the other hand, authorities in their guise as commissioners of health care services lacked a language of priority-setting to legitimate essentially moral decisions about priorities.

In the previous chapter it was argued that the reform process (based on a neo-liberal 'free' market rationale) led to the fragmentation of health governance and placed constraints health authorities' commissioning role. The case-study evidence presented in this chapter clearly shows that the imposition of the same consumerist rationale did indeed lead to the fracturing of the voice of the consumer. It was clear that the various groups that influenced local priority-setting - GPs, user/carer groups, CHCs - all had their own agendas. Using a governmentality approach, the substantive point is that this fracturing of the consumer voice into several, potentially conflicting, agendas is not to be viewed as a 'failure' of health governance to be rectified, but is an intrinsic part of it. As argued in the previous chapter, the problematisation of health using a discourse that is essentially economic in character presents a theoretically coherent form of governance. However, the means by which this neo-liberal economic discourse is re-conceptualised within health governance (so as to make health amenable to a new form of political calculation) can only be achieved by a re-conceptualisation of consumer sovereignty. In effect, because individual consumer sovereignty is not accessible, the

commissioning authorities have to construct a proxy consumer in the form of an aggregation of disparate needs and desires. However, it is arguably the case that many groups will legitimately represent consumer values even if they do conflict with others (as in the case of β-Interferon and recombinant factor VIII). Therefore, the totality of consumer opinion cannot be accessed through these groups. For specific developments this is often acceptable, but in terms of the 'big priorities debate' it falls well short of what is needed. Therefore, the expectation that the reform process will start a new era of explicit rationing may be unfounded.

Chapter 9

Conclusion: reviewing the evidence and looking to the future

Introduction

This chapter recapitulates some of the key theoretical issues that emerged in the preceding chapters and the empirical evidence about the central theme of the thesis, the management of priorities within a state health care system. Additionally, there will be a brief discussion of contemporary policy making as exemplified by the 1997 White Paper *The new NHS: modern, dependable*. The White Paper was the first substantial policy document produced by the new Labour government. As part of their manifesto pledges, the Labour party had committed itself to the a partial dismantling of the Conservative reform process, including the abolition of the internal market and the ending of the 'two-tier' service supposedly brought about by GP fundholding. The implication for the theoretical framework employed in this thesis - the notion that contemporary politics reflects a neo-liberal form of governance - could be quite severe. The empirical research presented in the previous chapters might be overtaken by events, since it describes a form of governance which may no longer apply to contemporary policy making. However, the contention in this chapter is that governmentality analysis can accommodate changes in political regime and still present valuable insights into the new policy direction for the NHS.

Establishing the governmentality framework

The ambition of Chapters 2 to 4 was to make the case for governmentality as an analytical framework and a practical methodology, that could account for changes in contemporary welfare policy. In an effort to establish the usefulness of governmentality analysis as an example of postmodern or post-structuralist thinking, it was contrasted with post-Fordist frameworks. The contrast was heightened by the fact that post-Fordism has proved an influential model in the theoretical understanding of the modern welfare state (see Jessop 1989; 1991; 1992; 1994), but only partly influential in the analysis of health service provision (see Harrison et al. 1992). Both theoretical

frameworks, post-Fordism and governmentality, use the same historical evidence to situate changes in welfarism as resulting from a shift in regulatory regime. However, as Harrison (1998) notes, 'whilst post-Fordism and postmodernism have a number of insights and observations in common... they imply fundamentally different epistemologies' (Harrison 1998: 27). The value of the post-Fordist comparison is that it is a prime example of a framework that relies for its epistemological coherence on the presentation of a grand or meta-narrative. In comparison, postmodern approaches reject the grand narrative framework. The question is whether rejecting this narrative, postmodernism also rejects a belief in some kind of 'progressive' politics based on 'universal' notions as citizenship and individual rights (see Taylor-Gooby 1994). One of the strengths of the postmodern approach is that concepts which rely on universalism are themselves challenged, often to reveal tacit assumptions about race and gender (Williams 1994). But this strength is also a weakness. Postmodern analysis critiques and disrupts the neat categories associated with grand narrative epistemologies, but what postmodernist analysis does not do, or even attempt to do, is provide an alternative unique epistemology to put in place of grand narrative accounts. Therefore, it is open to question whether postmodernist analysis can be the basis of an alternative form of emancipatory politics. This is a telling criticism of postmodernism and it is a theme explored in Chapter 2. However, in that chapter there is no attempt to resolve the problem except to point out that postmodern ideas can be the basis of political action but only in the form of a personal politics not universal one. However, an argument was advanced that this does not prevent postmodern ideas from being of practical use.

Foucault's concept of governmentality is a case in point of a practical use for a postmodern/post-structuralist theoretical framework. Governmentality is the investigation of the discursive space which 'renders reality thinkable in such a way that it is amenable to political deliberation' (Rose and Miller 1992: 179). It provides a framework and a methodology with which to investigate the changes that occur within societies in response to shifts in the mentality of governance and the problematisation of the political space. Yet, the best one can say about such concepts as 'mentalities of governance' and 'problematisations of rule' is that they are essentially metaphors for describing lived reality, not descriptions of reality itself. As such, governmentality is

simply a 'heuristic device', nothing more (see Dreyfus and Rabinow 1986). However, if such an theoretical framework produces an interesting new understanding of the policy making process then it has proved itself to be of practical value as an analytical tool. If, on the other hand, it provides no new insight then it can easily be rejected without rejecting the entire analytical framework. Compare this with post-Fordist accounts. Post-Fordist frameworks do not deal in analogy and metaphor, they deal in 'ideal types' which are deemed to possess some kind of descriptive property associated with 'real' phenomena. To subscribe to a post-Fordist analysis argument is to subscribe to the underlying theory. The use of post-Fordist theory cannot be reduced to a simple investigative device. As Mohan argues, this leaves authors who wish use this strategy open to the accusation 'of borrowing the terminology without subscribing to the theory' (Mohan 1996: 680).

One significant insight derived from the governmentality approach is that it introduces a new account of power relations between the various parties that influence the policy making process. This was explored in Chapter 3. In effect, governmentality presents a telling critique of many contemporary analyses of policy formation (in terms of health policy see Navarro 1978; Ham 1992; Harrison et al. 1990; Allsop 1995). Probably the most influential approach that is critically discussed in the chapter is that of Robert Alford (1975) and his use of the concept of 'structural interest' as a factor in the production of health policy. The Alford approach was critically assessed on two counts. The first was an examination of the usefulness of the Alford model within the context of the NHS. The second, more substantive consideration, concerned Alford's concept of power as a separate entity linked to structural interests. For Foucault, power is indivisible from knowledge, they are both aspects of a discourse which *creates* the categories of individuals that provide the subjects of that power. Therefore, governmentality is not a methodology for identifying those individuals, groups or institutions who somehow possess power over others through their position within a particular organising structure. It is a means of understanding how a power/knowledge discourse develops certain technologies of government through which groups and individuals are legitimised in their use of power over others. In this instance, one of the key technologies of regulation is embodied in the concept of 'expertise' (see Chapter

4). It was argued that the welfare state, and therefore the NHS, is itself a nexus of regulatory technologies that function within a particular formula of liberal governance.

Therefore, another of the strengths of the governmentality approach in that it able to present an analysis of both discourses and practices within the same framework. For example, in the discussion of power relationships above it is evident that many of the analyses of the these relationships are at a very high level of abstraction. In the case of governmentality, with its incorporation of the concept of power/knowledge, it is possible to move quite easily from the abstract notion of a 'mentality' of governance to the real effects it has through the subjectification of individuals within discourse. As such, governmentality analysis is ideally suited to the collection of empirical data in that it identifies concrete issues which result from the subtle interplay of discourse and practice.

This comprehensiveness and the facility to move between levels of analysis is not shared by other theoretical approaches mentioned in previous chapters. The concept of 'structuration' associated with Giddens, mentioned in Chapter 2 because of its similarity with Foucault's formulation of agency for subjects within a power/knowledge discourse, illustrates this point. The high level of abstraction of 'structuration' theory makes it difficult to operationalise empirically, whereas governmentality analysis can operate at both levels simultaneously. The same can be said of the Kuhnian notion of paradigm shifts alluded to in Chapter 6. The analogy between shifts in liberal governance and paradigm shifts in the natural sciences is self evident. However, in contrast to the Kuhnian theoretical scheme, the ability to explore the concept empirically is easily done within governmentality, in that a practical method of investigation (Foucault's concept of genealogy) is embedded within the analytical framework. Furthermore, the ability to move from abstract concepts to the exploration of real practices is not at the expense of a loss of coherence.

However, this coherence does have its consequences, the most problematic of which are the epistemological problems associated with governmentality analysis. In many respects this does represent something of a trade-off - epistemological rigour against coherence. As previous chapters have demonstrated, the epistemological problems of

governmentality, and Foucault's position in general, are difficult questions to resolve definitively. They are perhaps irresolvable. But all analytical frameworks have their difficulties and it is often the case of selecting a theoretical framework which is best suited to the problem to be investigated. The thesis argues that the problem of understanding the changing nature of health care within liberal regimes is a suitable subject for governmentality analysis, and that the chapters in Part 2 provide examples of its empirical application.

Liberal health governance

The theme that runs through the thesis is that the creation of the NHS represented a solution to a problematisation of health governance posed within a particular formula of liberal governmentality, termed 'welfare liberalism'. One of the characteristics of this formula of health governance was that it was based on concepts of solidarity and the collectivisation of social risk. Moreover, this emphasis on collective provision was accompanied by increased autonomy for the medical profession as practitioners of the dominant form of regulatory expertise. The consequence for those with political or managerial responsibility for the health system was that this provides only limited strategic control over the evolution of health care priorities. However, the arrival in the late 1970s and 1980s of a new formula of liberalism based on neo-liberal economic theory, initiated a re-problematisation of health care that re-articulated health governance within a market environment. This new form of neo-liberal health governance, with its rhetoric of empowerment and choice, placed great emphasis on personal responsibility, in effect re-coding many health problems as social problems amenable to solution through changes in individual behaviour. Therefore, it becomes the duty of the individual to engage in a form of self-entrepreneurialism of health, a kind of 'prudentialism', to avoid risky behaviour that would place an unnecessary burden on the rest of society.

An additional consequence of this the new formula of health governance is that management of the health system becomes associated with 'commissioning' health care to meet local health needs through the operation of effective and appropriate purchasing and contracting. Commissioning implies a more pro-active management

style and a new relationship with professional expertise. The reforms initiated by *Working for Patients* in 1989 introduced a package of novel technologies aimed at furthering control over the health care system. The development of internal market, the wider use of audit and evidence based medicine, all hinted at new methods of managing expertise. Potentially these technologies could create a market in expertise, where professionals must compete with each for scarce resources by demonstrating the clinical effectiveness of proposed treatments and therapies. The other side of this is that priority decisions will become more explicit and potentially more overtly political. Therefore, managers have to secure legitimacy from consumers of health care by some means to 'de-politicise' the issue of priority setting. However, the absence of a 'neutral' market in health care means that the construction of a technical quasi-market and the use of its associated technologies, provides only a partial legitimisation for the priority decision-making process. The problem for managers commissioning health care is that consumer interests are translated as health needs, and become part of the priority-setting agenda, through the mediation of a number of other groups and institutions, such as GPs, user/carer groups and Community Health Councils (CHCs). The practical question then is whether purchasing authorities can devise a coherent priority-setting agenda that reflects fragmented consumer interests?

Assessing the evidence

In Chapters 7 and 8 empirical evidence derived from interview data was presented that explored many of the topics outlined above. The purpose of this section of the chapter is to present a brief résumé of these findings and discuss them in the context of other surveys of post-reform health authority and CHC activity.

The main finding from Chapter 7 was that commissioning, as conceptualised within neo-liberal health governance, was seen by all authorities as their primary role. Moreover, commissioning reflected a strategic vision for the provision of local health care. The strategic framework of commissioning appeared to reflect a wider understanding of health and health need. The language of 'health gain', health promotion and disease prevention programmes emphasised the quality of life aspects of health care rather than the narrow definition of health based on absence of disease and

disability. This was often accompanied by calls for people to be made aware of their responsibilities when using the health service. The notable consistency between authorities pointed to a common ideology that underpinned their thinking. In its purest form, this ideology resembled that associated with 'New Public Health' strategies discussed in Chapter 3. However, it was argued in the Chapter 7 that the ideology associated with neo-liberal health governance was only one part of a multi-layered form of health governance within the NHS.

One of the more interesting findings of the research was the virtual absence of the language of competition. This was slightly surprising given that one of the most important elements within the reform process was the creation of an 'internal market' in health care. However, in terms of governmentality analysis, the failure of a language of competition to develop would appear to be directly linked to the fracturing of governance within health care. In support of this argument, the evidence indicated that one of the reasons why a competitive market had not emerged (apart from the technical difficulty that many Trusts were monopoly of suppliers of health care services within an area) was that marketing of services by Trusts was antagonistic to the health authorities' commissioning remit. It was clear that many of the authorities conceived of commissioning as having both supply and demand elements. On one hand, commissioning was realised through the technical function of purchasing and contracting. Yet, on the other hand, it was also concerned with shaping supply. However, Trusts, as part of their remit within the internal market, were in effect in competition with each other, looking to increase activity not decrease it. The implication was that the internal market for health authorities was actually an obstacle to commissioning and the efficient distribution of health resources.

The assertion that competition was in effect being suppressed by the authorities in the sample was supported by the evidence as to the function of contracting within commissioning activity. It was clear that contracting was <u>not</u> primarily a mechanism for expressing market relationships between authorities and Trusts. The evidence pointed to four other functions for contracting that reduced the impact of competition in the internal market. The four functions of contracting were:

- to managing supply
- to distribute financial risk
- to act as a disciplinary mechanism
- to increase stability in the health service

All the indications pointed to a complex relationship between authorities and Trusts. Significantly, and contrary to earlier findings, such as Freemantle et al. (1993), these were not characterised by 'provider capture', but of an emerging dominance of the relationship by health authorities. At times the contracting procedure appeared to reflect the idea of 'soft' contracting where contracts took on a more symbolic meaning, taking into account pre-existing relationships based on trust that countered the need for highly specified contract negotiation. At other times the evidence suggested a more antagonistic relationship, in which contracts played their part as mechanisms of control. The use of technologies such as audit, accreditation and 'care pathways' and effectiveness criteria were deployed as part of these mechanism of managerial control. However, although it appeared that authorities were developing technologies that made them the dominant partner in the purchaser/provider relationship, all authorities to a large extent felt that their commissioning remit was being constrained by demands to meet criteria laid down at the regional or national level. Many of the national initiatives associated with this 'macro' level of governance, such as *Health of the Nation* targets or calls for a 'primary care led NHS', did coincide, or could be made to coincide, with local priorities. However, other pressures from the centre to demonstrate activity, such as meeting efficiency index targets and to a lesser extent reducing waiting, were considered to be political in origin and a distraction from the authorities 'proper' role of commissioning. As suggested in Chapter 7, this fracturing of governance is not to be regarded as a failure of the new health discourse but as an inevitable product of it. It is argued that conflict between different levels of governance will not be resolved by further policy initiatives. This is simply because each of the three levels of governance represents a different aspect of the same neo-liberal regulatory discourse. However, it is only by fracturing governance that the discourse can make health care amenable to a form of political calculation. Therefore, the

governance of health care within this neo-liberal form of health governance will remain highly political.

The difficulties for health authorities in setting local priorities in health care as part of their commissioning remit were explored in Chapter 8. The evidence suggested that authorities approached the priority-setting agenda with a subtle mixture of sophistication and pragmatism. The authorities appeared to have no appetite to indulge in a large-scale reorganisation of priorities. The two main reasons appeared to be that firstly, the constraints placed on authority activity (described above) dominated the authority's priority-setting agenda and left the authorities only limited discretion over arrangement of local priorities. The second reason reflected the belief of many of the directors questioned that health care was intrinsically too complex to be reduced to simple economic calculation. This was reflected in an ambivalence towards rationing technologies such as QALYs or an Oregon-type solution. Instead the authorities appeared to be adopting a more pragmatic approach to priority setting that depended on the use of other more managerial technologies such as audit, clinical effectiveness and evidence based medicine that provided a calculus of trust between management and expertise. It is these technologies that dominated discussions about priorities.

One of the surprises that emerged from discussion with directors about priorities was the similarity between 'rationing' policies. Only one of the authorities in the sample had published in its purchasing plan an explicit rationing policy. Yet it was clear from the interviews and other documentary evidence, even for authorities that had not declared that they were engaging in a rationing debate, that each of the authorities had a similar list of services that were restricted. The type of services on these list have been described many times by other surveys of authority activity (see Redmayne et al 1993; Redmayne 1995; Klein et al 1996). In general, they were marginal, low-volume, services operating at the boundaries of authority responsibility, usually purchased as ECRs. In essence, the restrictions imposed on these services was part of an ECR policy based on clinical effectiveness criteria. However, it was unclear from the interview data whether these ECR policies would (or could) form the basis of general rational policy.

Therefore, despite this consistent approaches to rationing marginal treatments, it was not apparent, as Harrison and Wistow (1992) observed, how this could develop into a wider rationing technology that could be conveyed to the public. The pragmatic position adopted by many directors was that a more explicit rationing, or priority-setting decisions, could only take place against a background of relatively easily to understand 'common sense' sets of principles. The difficulty appeared to be that these sets of principles operated at such a high degree of generality that any expectation of a consensus necessary to legitimise rationing decisions was thought unrealistic. The experience of several directors of discussions on priorities within the authority only reinforced this opinion. This was reflected in the attitudes of some directors that techniques such as Rapid Appraisal and focus groups - as a means of eliciting the views of the general public on local health needs - would have only a limited impact on the priority-setting agenda. Therefore, health authorities sought legitimacy for their actions from other sources.

The main influence on priorities were the opinions of GPs - as has traditionally been the case in the NHS. The evidence from the data suggested that that GPs were being incorporated into the decision making process because of two factors: that they represented a form of expertise at primary care level; and that they acted as 'proxy consumers', acting in their patient's best interests. However, it was apparent that this was only of limited value to authorities when pursuing their commissioning remit. When GPs acted in their patient's interest (or their own self-interest) they could not be relied upon to take into account the health needs of the whole district and act strategically when deciding on treatments for their patients. This problem was repeated when authorities incorporated other groups, such as user/care representatives, into the strategic commissioning process. The case of β-Interferon and recombinant factor VII highlighted in Chapter 8 illustrate this point. The evidence supported the assertion that these groups were useful to authorities because they were able to bring an unmediated understanding of user and carer health needs to commissioning. However, caution was expressed by some directors that many of the groups were naturally partisan, and this needed to be taken into consideration when including them in service development discussions. Even so, it was clear that in a number of the sample authorities, user/carer

groups had more influence on the commissioning process than the official consumer representatives in the district, the Community Health Councils.

Within the sample of health authorities, five out of six, and a majority of the directors interviewed, described CHCs as having only a marginal impact on their health authority's commissioning agenda (see Lupton et al. (1995) for a similar finding). This was despite the fact that health authorities saw CHCs as being **more** representative of the local population than the health authorities themselves. Although some health authorities were keen to include CHC representatives in some aspects of the commissioning process, in general the authorities were dismissive of CHC input (for similar findings elsewhere, see Harrison and Wistow 1992). As Barnes and Cox (1997) have also observed, a number of the authorities suggested that it was more appropriate to seek representative views from user/carer groups and voluntary organisations rather than engage in discussion with the local CHC. When CHCs were involved in discussions on priorities, CHC insistence that to preserve their own independence they could not be bound by any decision, was often interpreted by authorities as indicating that CHC were not serious players in the priorities debate.

Summing-up the evidence

In terms of governmentality analysis, the principal theme that emerges from the empirical data presented in chapters 7 and 8 was of a new form of pro-active management within health authorities struggling to operationalise their commissioning remit. It was clear that the new discourse of health care management which had created this strategic commissioning role was not entirely reflected in the practices of health authorities. It is argued that the fragmentation of governance and the resulting conflict of interests between providers, commissioners and politicians limited the ability of authorities to implement an explicit 'change agenda' and re-organise the historical pattern of services. The evidence suggested authorities have not developed the means of entering into a explicit priorities debate for two basic reasons. The first is that authorities could not rapidly change the historical pattern of services even if they wanted to, because of the constraints placed on their activities by national imperatives.

The second reason is that explicit priority setting involves making judgements about social values not just about allocating resources. This difficulty was compounded by the fragmented voice of consumer interests. The technologies of audit, clinical effectiveness and evidence based medicine, only take priority-setting debate so far - in terms of cost-effectiveness. As such they are valuable tools in the management of priorities. However, governmentality analysis strongly indicates that the inherent contradictions within neo-liberal health governance means that the ability of commissioning authorities to make legitimate calculations of costs and benefits when devising those priorities will remain just beyond reach.

Future directions: ***The new NHS: modern, dependable***

As mentioned in the introduction to this chapter, in 1997 the new Labour government produced their first substantive document on the future direction for the NHS. The White Paper entitled *The new NHS: modern, dependable* outlined six key aims for the new health policy. They were:

- First, to renew the NHS as a genuinely national service. Patients will get fair access to consistently high quality, prompt and accessible services right across the country

- but, second, to make the delivery of healthcare against these new national standards a matter of local responsibility. Local doctors and nurses who are in the best position to know what patients need will be in the driving seat in shaping services.

- Third, to get the NHS to work in partnership. By breaking down organisational barriers and forging stronger links with Local Authorities, the needs of the patient will be put at the centre of the care process

- but fourth, to drive efficiency through a more rigorous approach to performance and by cutting bureaucracy, so that every pound in the NHS is spent to maximise the care for patients.

- Fifth, to shift the focus on to quality of care so that excellence is guaranteed to all patients, and quality becomes the driving force for decision-making at every level of the service

- and sixth, to rebuild public confidence in the NHS as a public service, accountable to patients, open to the public and shaped by their views.

(DoH 1997: 11)

To meet these aims, the new government committed itself to the abolition of the internal market, but to retain the 'purchaser/provider split' and replace contracts with long-term 'service level agreements'. However, the main change is in the commissioning function. The plan as outlined in the White Paper, is that the primary

responsibility for purchasing and 'commissioning' will be gradually devolved, over a four-stage process, to 'primary care groups' comprising GPs and community nurses. The consequences for health authorities will be significant. The White Paper outlines seven key responsibilities for health authorities. These are:

- assessing the health needs of the local population, drawing on the knowledge of other organisations
- drawing up a strategy for meeting those needs, in the form of a Health Improvement Programme, developed in partnership with all the local interests and ensuring delivery of the NHS contribution to it
- deciding on the range and location of health care services for the Health Authority's residents, which should flow from, and be part of, the Health Improvement programme
- determining local targets and standards to drive quality and efficiency in the light of national priorities and guidance, and ensuring their delivery
- supporting the development of Primary Care Groups so that they can rapidly assume their new responsibilities
- allocating resources to Primary Care Groups
- holding Primary Care Groups to account

(DoH 1997: 25)

In effect, the proposals in the White Paper restrict the District Health Authority's role to one similar to the former Regional Health Authorities. However, the detail of the new health authority role is not really the issue under discussion. The more important question in the context of this thesis is whether the new plans for the NHS represent a shift in the formula of health governance? The new arrangements for health authorities raise a number of key issues discussed in previous chapters, such as management control over the priority decisions and forms of legitimacy. Indeed, many of the problems are heightened by the proposed changes, in particular, the problem of maintaining strategic oversight and overcoming the traditional individualistic culture of GPs if they are to work together, and with others, within the new co-operative ethos of the 'primary care groups'. As always, 'the devil is in the detail', but the weakening of health authorities' power does seem to compromise the strategic nature of commissioning. In combination with the ending of the internal market this appears to be a radical re-working of health governance. Yet in other spheres of government activity, social security, education and law and order, many of the themes associated with neo-liberal governance such as personal responsibility and questioning the limits of government activity, are still articulated as part of new Labour philosophy.

The question of a new formula of health governance is thus still open. One of the key points is whether the internal market, contracting and the purchaser/provider split are separate elements or intimately linked. If one of the elements is removed does this mean that the whole structure of governance collapses in on itself? Or are they separate and mutually independent elements, none of which are essential factors in determining the form of health governance? The question is made more difficult because much of the terminology is still imprecise. What exactly are 'service level agreements'? Are they contracts by another name? This reflects the nature of the new proposals themselves. Do they represent a 'radical vision of the future' for the NHS (Ham 1998: 3)? Or do they still retain 'the key elements of the old internal market' (Glennester and Le Grand 1998: 19)? At this early stage of development, deciding which of the two is correct is virtually impossible.

However, the evidence presented in earlier chapters does provide some insight into the new proposals. For instance, the evidence suggested that contracts were becoming more long-term, privileging stability over competition. It appear that 'service level agreements' are similarly constructed, so it may mean that little in effect will change in the relationship between commissioner and provider. Again the evidence suggested that competition played only a limited part in the internal market, so abolishing the internal market but retaining the purchaser/provider split may be less radical than at first anticipated. Many of the key technologies of associated with the previous form of management, such as audit and evidence based medicine, will be retained. In fact there use will be institutionalised through the creation of a 'National Institute for Clinical Effectiveness' (NICE) and a 'Commission for Health Improvement' (CHI), to disseminate good practice and monitor quality standards. Clearly the most radical difference is in the creation of the 'primary care groups' to take over commissioning. However, even here there are echoes of the past. In Chapter 6 there was a brief discussion of Enthoven's (1995) original plan for the NHS modelled on the Health Maintenance Organisation (HMO) system in the US. With the creation of the primary care groups perhaps it is an idea whose time has come, and new modalities of health governance will evolve.

Using the Foucauldian framework of 'governmentality' it can be seen that the discourse of rationing and priority-setting in the NHS, and the institutional practices in which it is embedded, operate at a much more fundamental level than surface political activity would indicate. It is clear that the shift to a neo-liberal form of governance (and the subsequent shift to a neo-liberal form of health governance) has created a new means of conceptualising lived reality - a process of making it amenable to political calculation. This new mentality of liberal government creates a discursive space in which political activity becomes 'thinkable' and which in turn defines the ambitions and limits of policy action. Therefore, it is clear that radical change in the governance of health care only comes about through a shift in the problematisation of liberal governance, not merely in the transition from one political regime to another, although the two may coincide.

Appendix A

Methodology

This thesis is based on a case study sample of six English District Health Authorities and their constituent Community Health Councils (CHCs), with data generated principally through semi-structured interviews. Other methodologies that have been used in previous studies of health authority activities were considered and rejected for differing reasons. The two dimensions that were taken into account as part of the procedure to select a case study research design were: a) the relevance of the methodology to the research question explored in the thesis; and b) the practical limitations involved in PhD research.

Initially, a methodology based on questionnaires was considered as a practical option (see Appleby et al. 1992; Appleby 1994). The advantage of this method is that it allows one to survey a large population relatively cheaply. The disadvantages are that the questions used must be drafted very precisely to avoid ambiguities and maximise the amount of information generated. One of the problems associated with this methodology is the potentially low return rate and the acknowledged possibility that those questionnaires that are returned may have been completed by individuals other than the intended recipient who may not be in a position to fully answer the questions posed. However, the most important problem associated with this method, in the context of this thesis, is that the research problem is in part about the discourse and 'mentality' of governance. As such it is not about the measurement of activity but about the shared symbolic meanings involved in devising health priorities.

This latter problem is also apparent in methods that depend upon examining published materials (see Klein and Redmayne 1992; Redmayne et al. 1993; Redmayne 1995). Although this method is a useful starting point when embarking on a research project, it soon becomes clear that there are inherent limitations when it is used as the sole basis of research. Logistically, it is a very practical method. However, the nature of the public documents being studied are often of such a high level of generality or are very formal in their presentation that they do not convey the ideological context in which

the document is produced. So it is important to develop the methodology beyond the analysis of officially published documents and to engage directly with those who produced the original material.

One method that would allow for direct observation of the policy making process if that of the ethnographic approach (Harrison et al 1992; Pollitt et al. 1990). This form of research, which involves studying behaviour in a 'natural' setting, would be an ideal means of exploring the interaction of forces, and the underlying assumption, that influence the production of policy. However, the difficulties associated with this methodology are the problems of access and time, as well as the logistics of field observation. The limited resources of PhD research place severe constraints on the ability to observe the full cycle of policy making. Additionally, there is the problem of securing sufficient and continuing access to key informants. In the case of health authorities, the confidential (and controversial) nature of much of their work may make it 'off-limits' to most postgraduate researchers.

In the light of the above, it is evident that the methodology of the case study, using semi-structured interviews is a form of compromise. However, the use of case studies and the collection of interview data is itself a robust and well-established methodology. Its use in this thesis follows similar methodologies employed in many influential studies of managerial behaviour within the NHS (see Harrison and Wistow 1992; Ranade 1995; Flynn 1992). However, the particular use of case study in this thesis is something of a compromise. The central theme of the thesis is understanding the context in which priority debates take place. But because of resource and time constraints, and the problems of defining a representative sample and arranging access, there was no attempt to collect data from groups who have input into priority decisions other than health authority directors and CHC Chief Officers. The most important omission is interview data from GPs (fundholders and non-fundholders). However, to partially compensate for this, there were devised a number of question in the interview schedule for directors that specifically addressed the nature of GP involvement (see Appendix B).

The case-study selection procedure

The empirical evidence in this thesis is derived from semi-structured interviews conducted separately with the Chief Executives and principal directors of six English District Health Authorities. Using the revised RAWP formula (see Peacock 1995; Peacock and Smith 1995), sixty-three Health Authorities (HAs) were initially selected to cover a wide range of potential 'winners' and 'losers' from the RAWP process as well as providing a selection of metropolitan, inner-city and rural Health Authorities. A letter was sent requesting a selection of information from each of the HAs. This included budgetary data, Purchasing Plans for 1996/7 and the Authority's current Public Health Report. Of the original sixty-three selected HAs, five had ceased to have a separate identity due to mergers, forty-five sent Public Health documents and thirty-five Purchasing plans for 1996/7, several others sent plans for previous years or long-term strategic plans. Usually some financial information pertaining to RAWP allocation was included in purchasing documents. The documents were analysed closely and formed the basis of the selection procedure. They also provided a degree of 'triangulation' when considering the interview data. After a review of Purchasing Plans, a number of District Health Authorities were selected from those authorities that acknowledged the rationing debate in their purchasing intentions and represented a cross-section of gainers and losers with respect to the new funding formula.

To some degree the selection procedure was obscured by the fact that in several HAs it was unclear, at the time when the purchasing plans were being produced, which RAWP formula was being used, the old one or the new formula with its 'acute' weighting. This was relevant to the categorisation of HAs as winner or loser. One additional aspect of the document review was to see if RAWP funding patterns influenced patterns of priorities. The review highlighted a large degree of variation in the type of treatment and therapy that were candidates for disinvestment and which were considered to be priorities. The many treatments and interventions that were regarded as priorities in one HA yet candidates for disinvestment in others, became the object of future investigation and interest.

Table 2 List of participating directors for each Health Authority in the sample

A	B	C	D	E	F
Chief Executive	Chief Executive	Chief Executive	Chief Executive	Director of Public Health	Chief Executive
Director of Commissioning	Director of Finance	Director of Contracts	Director of Strategy	Director of Purchasing	Director of Public Health
Director of Primary Care	Director of Public Health	Director of Public Health	Director of Commissioning	Director of Commissioning	Director of Primary Care
Director of Finance		Director of Service Development	Director of Public Health	Director of Finance	Director of Strategy

Selecting the case study sample and arranging access

After this review and selection procedure twelve health authorities were approached for interview. A letter was sent to Chief Executives (and in one instance the Chair of the Authority) asking for help in the research in the form of semi-structured interviews. Of the twelve, four agreed to participate in the research immediately and two more authorities agreed after a further request was sent. The rest of the authorities declined the request for help in the research process. Within the final sample of **six** authorities there were several different types of authority - city, urban/rural etc., a range of population sizes, variable levels of GP fundholding, and they were geographically spread across northern England. All of the sample authorities were situated in one of two NHS Regions. Additionally, two of the authorities were committed to locality funding with one discussing it as a future option. In terms of funding, three authorities were below their target allocations and three above target, one significantly so. However, with the exception of one authority, it has to be noted that most of the authorities were relatively close to their targets.

The sample of authorities were contacted again and interviews were arranged with directors who had agreed to participate in the study. A table of participating directors (Table 2) is reproduced above. As part of the agreement of anonymity for the authority and individual directors each authority has been given a code letter (the same letter are used in chapters 7 and 8 for participating authorities) and the titles of directors standardised so that no unique title could identify an authority. The interviews took place on health authority premises with only the director and interviewer present. The

schedule for the semi-structured interviews is reproduced in Appendix B. The average length of interview was approximately one hour. Each interview was tape recorded and later transcribed and analysed. The total number of interview in this section of the research was twenty-three. The interviews took place between July 1996 and January 1997.

Selection of Community Health Councils

After the interviews with health authority directors were completed, a letter was sent to all the Chief Officers of CHC within the districts of the sample authorities asking for help in the research. Of the total of thirteen CHCs, nine Chief Officers agreed to participate in the research. The same conditions and methodology as applied to authority directors was used for CHC interviews. All interviews with Chief Officers were tape recorded. Each respondent was guaranteed anonymity for themselves and the CHC. The average length of interview was approximately 45 minutes. The interview schedule is reproduced in Appendix C. For each of the sample authorities at least one Chief Officer of their constituent CHCs were interviewed. In certain instances all the CHCs were interviewed. This part to the fieldwork took place between March 1997 and July 1997. Once the fieldwork was complete all the transcripts were collated and analysed.

Conclusion

Overall, it is believed that the case-study approach has yielded valid qualitative data which are of wider relevance beyond the areas in which fieldwork was conducted, and provide valuable empirical evidence for the theoretical analysis undertaken in this thesis.

Appendix B

Interview schedule for health authority directors

Organisation

1. How is purchasing activity within the Authority organised?
2. Could you tell me how your purchasing plan is put together?
   a) Are there working groups for particular areas?
   b) What is the composition of these groups - from which directorate are individuals drawn?
3. Is contracting separate from commissioning in the Authority?
4. Has the type of contracts negotiated with providers changed over the last two years?
5. To what extent is investment in local priorities constrained by national policies such as 'Health of the Nation' and waiting lists initiatives?
6. Does the HA anticipate any new growth money as a consequence of the new funding formula?

Health Needs Assessment and GPs

Health Needs Assessment

1. What form of health needs assessment is used by the HA?
   a) Rapid Assessment
   b) Focus groups
   c) Priority debates etc.
2. In what way has HA purchasing policy been informed by local health needs assessment?
   a) Could you give me an example?
3. In your view, how have the local CHCs influenced commissioning strategy and the production of the purchasing plan?

GPs

1. How are GPs incorporated into the purchasing decision making process?
2. How are GP views made known to you?
3. Are there differences of view on priorities between fundholding and non-fundholding GPs?
4. To what extent do you think there may be a potential conflict between GP interests and the HA's wider remit?

Priority Setting

Discussion

In recent years there has been a vigorous debate about how to make the best use of limited resources to provide the maximum effective healthcare. Inevitably this will

involve determining priorities for funding and implies that in future some services may not be funded.

1. Has your authority debated the need to disinvest in some services?
2. Could you say more about the process involved in assessing individual services?
   a) Is there a specific working party for this issue?
   b) Which individuals are involved?
   c) What criteria are used?
3. Many authorities have produced a specific list of services in which to disinvest, does your authority have a similar list or expect to produce one in the near future?
4. Does the use of evidence based medicine inevitably entail challenging current clinical practices?
   a) One authority has stated that 'reviews of existing research evidence have been used to direct policy, sometimes challenging clinical viewpoints'. Could you comment on this?

Protocols, Guidelines and Clinical Audit

Discussion

In many current purchasing plans it is evident that guidelines and protocols and an enhanced role for clinical audit are being incorporated into the purchasing and contracting process.

1. Is the use of protocols and guidelines part of this authority's commissioning process?
2. From where do these protocols and guidelines emanate?
3. To what extent are medical professionals involved in approving the use of protocols and guidelines in commissioning?
4. Another HA suggests that the Clinical Audit system needs tightening so it 'becomes a purchaser driven activity which can lead to changes in purchasing and contracting to the benefit of the population' (East Lancs. p 13). Does this authority envisage a similar role for Clinical Audit?

Appendix C

Interview schedule for Community Health Council Chief Officers

Community Health Councils

Organisation

1. How is the Community Health Council constituted?
2. How many members are there?
3. How difficult is it to persuade people to become members of the Community Health Council?
4. How do you gauge the opinion of the local population?
5. Do you see your representativeness as problematic because members are appointed not elected?

The role of the CHC

1. What is the role of the Community Health Council?
2. How is your workload balanced between working with the Health Authority in commissioning and developing services, and following up complaints and ensuring service quality?
3. In an ideal world what role would the Community Health Council fulfil?
4. Do you think that your local District Health Authority regards you as a major stakeholder when discussing policy?

Relationships and Influence

1. How much influence do you have over the final draft of the Health Authority Purchasing Plan?
2. How much influence do you have on the Health Authority's priority setting agenda?
   a) Could you give me a recent example of where you have been able to modify new service developments and rationalisation?
3. Do you or the Health Authority best represent patient interests?
4. Should Health Authorities and Community Health Councils be directly elected?
5. When new services are being developed do the other user/carer groups work through you to influence outcomes?

Priorities

In recent years there has been a growing, and increasingly heated debate, about rationing health care.

- Where does the Community Health Council stand on this issue?

In the US, in states like Oregon, these issues have been discussed openly by local citizen groups and rigorous lists of priorities produced.

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