1 Introduction: ‘Modernizing’ the NHS

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Introduction: New Labour and the ‘modernization’ of the NHS

Since coming to power in 1997, the Labour government has placed the National Health Service (NHS) at the heart of a concerted drive to ‘modernize’ public sector services. ‘Modernization’ is a loose term that is capable of multiple meanings and interpretations and that also has significant normative overtones – who would eschew modernization in favour of ‘old-fashioned’ or ‘outdated’ public services? Modernization is perhaps most commonly used to refer to the process of updating services to match the expectations of contemporary publics or consumers. This may include attempts to tackle complex and long-standing social problems, such as the causes of avoidable morbidity and mortality and the wide variations in the use and experiences of health services by different sectors of the population. Modernization is also an implicit response to the challenges posed by economic globalization, in that it acknowledges the importance of maximizing efficiency in the use of public resources to sustain economic competitiveness. It therefore has the potential to open up to change those parts of the public sector that remained untouched, or failed to be transformed, by the market ethos of previous Conservative governments. This can involve challenging some cherished traditions and vested interests, such as those of professional groups who may attempt to protect their remaining autonomous domains from rationalizing managerial influences (Newman 2000, 2001).

However, unlike the politics of its immediate predecessors, who regarded taxation and public expenditure as more or less negative influences on economic competitiveness and who therefore sought to prioritize efficiency and value for money over most other concerns, the Labour government’s ‘modernization’ agenda also embraces a concern for social, moral and civic values. It therefore includes a strong appeal to principles of consensus and social
inclusion, and an awareness of the roles – both actual and symbolic – that high-quality public welfare services can play in building and sustaining social cohesion. Thus the continuing drive to improve efficiency is now accompanied by equally urgent pressures to improve the quality and responsiveness of services to improve outcomes for the individuals who use them.

Underpinning Labour’s ‘modernization’ project is the articulation of a ‘Third Way’, a pragmatic political paradigm that involves taking the ‘best’ (however defined) of both traditional, hierarchical, state-based welfare and more recent market approaches to social policy and building on these (Giddens 1998). Indeed, it has been argued that the Labour government’s appropriation of the term ‘modernization’ itself draws on several different traditions and meanings that incorporate both earlier and more recent conceptions of the contemporary state (Newman 2001). Thus, for example, since the government’s first 2 years in office during which it adhered to the public expenditure plans of the previous Conservative administration, very substantial amounts of new funding have been injected into key areas of public sector services. For 20 years before 1997, annual real terms growth in spending on the NHS had remained at around 3 per cent (‘real terms’ growth is the extra money available, relative to the expansion of the economy, with pay and prices held broadly constant). However, between 1997 and 2001, annual real terms growth in NHS spending doubled to 6.1 per cent (Jones 2001). Further increases in funding for the NHS were announced in the 2001 and the 2002 budgets, taking annual real terms growth to 7.4 per cent for the years 2002/3 to 2007/8. This level of real terms growth in NHS funding is almost three times higher and has been committed for a longer period than for the public sector as a whole; other public sector real terms growth remains at 2.5 per cent for only the 2 years 2004/5 and 2005/6 (HM Treasury 2002). In cash terms, the additional investment announced in the 2002 budget increased total spending on the NHS across the UK from £65.4 billion in 2002/3 to a projected £105.6 billion in 2007/8. Indeed, Paton (2002) has claimed that the most significant point in the evolution of Labour’s health policy occurred with the announcement of these new spending plans: ‘the message was clear: the jewel in New Labour’s crown, the NHS, required significant polishing’ (p. 127).

Although this level of investment bears a remarkable resemblance to ‘old’ Labour expenditure patterns, which privileged state over other forms of welfare, the conditions attached to these new resources and the ways in which they are to be spent reflect definitively ‘new’ Labour ways of governing. These ways include highly prescriptive approaches to the performance, delivery and results of public sector services. Indeed, the government has tied its electoral fortunes tightly to the attainment of these results: ‘New Labour has probably set itself more targets than any previous government in history . . . It has manufactured huge amounts of ammunition either to fire a celebratory salute or to shoot itself in the foot’ (Powell 2002: 7).
Chapter 2 expands on these points, describing in more detail Labour’s ‘Third Way’ philosophy and suggesting some potential implications of this philosophy for the government’s attempts to reform the NHS. In this chapter, the government’s ambitions for the NHS, the development of these policies and their implementation since 1997 are first described. We then explain the foundations on which these plans have been built – the legacies of the previous government’s quasi-market reforms and, in particular, the growing involvement of front line health professionals, such as general practitioners, in the processes of shaping services, ensuring cost-effectiveness, safeguarding quality and managing budgets. We go on to discuss the challenges of evaluation and the concept of success in the context of these reforms. This discussion is significant, given the Labour government’s proclaimed pragmatic commitment to building on ‘what works’. Should the performance and outcomes of a ‘modernized’ NHS be measured against the objectives that the government has itself set, for example, or against some external criteria – and, if so, what? Finally, we describe the rationale and organization of the rest of the book.

**Labour’s reforms: the ‘modernization’ of the NHS**

Just 7 months after coming to power in 1997, the Labour government published a White Paper setting out its plans for the reform of the NHS (Secretary of State for Health 1997). *The New NHS: Modern, Dependable* began with a clear exposition of ‘Third Way’ philosophy:

> In paving the way for the new NHS the Government is committed to building on what has worked but discarding what has failed. There will be no return to the old centralized command and control systems of the 1970s . . . But nor will there be a return to the divisive internal market system of the 1990s . . . Instead there will be a ‘Third Way’ of running the NHS – a system based on partnership and driven by performance.

(Secretary of State for Health 1997: 10)

The main structural changes proposed in the 1997 White Paper were: the abolition of general practitioner (GP) fundholding, in which some individual general practices or groups of practices held budgets to purchase a limited range of hospital and other health services for their patients; and the abolition of the internal market that had been introduced into the NHS in 1991. In relation to this latter proposal, the formal separation between the purchasers and the providers of services was retained, but competition was to be replaced by collaboration; indeed, all NHS bodies were to be placed under a
new statutory duty to work in partnership with each other and with other organizations. These transformed relationships would be underpinned by agreements, rather than annual contracts, governing the provision of services. Responsibility for ‘commissioning’ (broadly, planning and procuring services within an agreed budgetary framework) would increasingly lie in the hands of entirely new organizations – primary care groups (PCGs) and primary care trusts (PCTs). Primary care groups and trusts (PCG/Ts) would bring together GPs, community health services and other local health providers within a single organizational framework, and would be responsible for an integrated budget amounting to three-quarters of all NHS expenditure.

Primary care groups and trusts were – and remain – the organizational centrepiece of the new government’s NHS reforms. They represent a major innovation and undertaking within the NHS. Each PCG/T includes all the GPs within a locality, unlike fundholding which had been optional. Typically, a PCG/T would, according to the White Paper, include around 50 GPs and approximately 100,000 registered patients (no evidence was cited to justify this size). Primary care groups and trusts have three main areas of responsibility:

- To improve the health of local people and reduce inequalities, in relation to both the risks of poor health and the use of health services. Primary care groups and trusts are responsible, in close collaboration with local authorities and other local partner organizations, for drawing up a health improvement plan for the locality. This plan sets targets for reducing avoidable morbidity and the measures by which these targets are to be attained.
- To develop primary and community health services for the locality. This includes creating comprehensive, integrated local services out of the GP-based services that have hitherto remained largely separate, both from each other and from the community health services that, since the early 1990s, have been part of provider trusts.
- To commission hospital and community health services. This responsibility builds on the experiences of GP fundholding and other variants of GP-led commissioning that had developed during the internal market.

The 1997 White Paper anticipated that there would be four levels of PCG/Ts, characterized by increasing levels of devolved autonomy and independence. At level 1, PCGs would simply advise health authorities on commissioning services. Level 2 PCGs would have devolved responsibility for the budget for purchasing hospital and community health services for their patients, again operating as subcommittees of their health authorities. At the third level, PCGs would become trusts – free-standing NHS bodies, responsible both
for their own budgets and for commissioning services. At level 4, PCTs would also manage and provide a range of community health services, such as district nursing, health visiting and specialist nursing services. At levels 3 and 4, PCTs would have full responsibility for managing their budgets and would be accountable for their actions through mainstream NHS performance management arrangements.

The governance arrangements of PCG/Ts reflected this evolving status. The twelve-member boards of PCGs were dominated by primary care professionals – up to seven GPs and two nurses, with the GP members having the right to select the board chair. Other board members included a representative from the local social services department, a health authority representative and a lay representative from the local community. The PCG board formed the basis of the professional executive committee of the PCT – but, significantly, without an overall GP majority. Like other NHS trusts, PCTs also have boards, most of whose members are lay, non-executive members. However, unlike other NHS trusts, it is the PCT professional executive committee that is responsible for the formulation and implementation of local strategies and priorities; the PCT board has only oversight, not policy-making responsibilities (see Chapter 6 for further details).

A highly significant innovation was to give PCG/Ts a (notional or actual, depending on the level of PCG/T) budget that consists of a ‘single cash limited envelope’ (Secretary of State for Health 1997: 37). This is made up of three previously separate funding streams that had covered, respectively, spending on hospital and community health services; GP drug prescribing; and the cash-limited budget that had funded the infrastructure costs of GP practices – facilities such as premises, ancillary nursing and clerical staff, and computer systems. (The non-cash-limited budget covering remuneration for individual GPs was not included.) Integrating these formerly separate budgets offered the opportunity to make strategic shifts in resources and investment between areas of primary care provision that had hitherto been separately funded from entirely different budgets. Equally significantly, this ‘single envelope’ budget was determined in advance, rather than being demand-led and therefore largely open-ended. At the same time, it was announced that the basis for calculating the overall budget for primary health services across a locality or region would be altered. The traditional mode of reimbursing individual, independent contractor GPs meant that spending on primary care was heavily influenced by factors such as the number of GPs in a locality, the demands of patients, and the variable behaviours of individual GPs in prescribing, ordering diagnostic tests and referring patients to specialist hospital services. The resources allocated for general practice were, therefore, substantially demand-led and, over time, this had led to an inequitable geographical distribution of resources. Instead, the intention was to move towards a situation in which the resources allocated to PCG/Ts reflect the health needs of their populations,
through the application of a new ‘weighted capitation’ formula that takes into account the demographic and socio-economic characteristics of the population covered by the PCG/T.

The White Paper also emphasized the importance of accountability in the ‘new’ NHS – not in the wider sense of public, democratic accountability, but a much narrower, managerial accountability (Rouse and Smith 2002). Two new national bodies were established. The National Institute for Clinical Excellence would set national standards and benchmarks to reduce the widespread variations in professional practices and treatments that traditionally characterized the behaviours of autonomous, independent GPs and that had arguably increased during the 1990s. The Commission for Health Improvement (subsequently to become the Commission for Health Care Audit and Inspection) would ensure that these standards and benchmarks were adhered to, through a rolling programme of inspections. The White Paper also promised the publication of national service frameworks, to establish benchmarks for the treatment of particular common conditions or patient groups. Meanwhile, measures to safeguard the quality of primary care services were built into the responsibilities of PCG/Ts through the concept of ‘clinical governance’. This was intended to ‘build on and strengthen the existing systems of professional self-regulation and the principles of corporate governance’, by requiring ‘practitioners to accept responsibility for developing and maintaining standards within their local NHS organizations’ (Secretary of State for Health 1997: 47). These measures threatened to encroach on cherished clinical freedoms, through the introduction of increasing specification, standardization and centralization (Harrison 2002). Their presentation was, however, accompanied by eloquent appeals to the importance of equity and fairness; an end to the variations in patients’ experiences that had characterized the former internal market; and the re-creation of a one-nation NHS. At the same time, an array of new performance targets were introduced, including waiting times for access to primary and secondary health services, improvements in patient satisfaction, reductions in avoidable morbidity and good performance benchmarks.

The White Paper’s emphasis on managerial accountability was nevertheless complemented and, indeed, justified by the need to improve relationships between the NHS and the general public to rebuild public confidence; ‘the NHS, as a public service for local communities, should be both responsive and accountable’ (Secretary of State for Health 1997: 29). Public involvement in the development of health improvement programmes and in the activities of PCG/Ts was therefore promised, as were new surveys of patient and user experiences.

The proposals in The New NHS: Modern, Dependable (Secretary of State for Health 1997) applied only to England. Different variants were proposed in subsequent White Papers covering Wales, Scotland and Northern Ireland. In Wales, the members of local health groups were to offer GPs and other front-
line professionals the opportunity to influence service commissioning, again using indicative cash-limited budgets (Secretary of State for Wales 1998). Scottish plans proposed the establishment of local health cooperatives, with membership by GPs remaining optional. Vertical separations – between purchasing and provision and between primary and secondary services – were to be maintained through the creation of primary care trusts (responsible for primary health care, community hospitals and mental health services) and area health boards responsible for commissioning acute services (Secretary of State for Scotland 1998). A consultation document, *Fit for the Future* (Secretary of State for Northern Ireland 1998), set out two options for Northern Ireland. One of these resembled the proposals for PCG/Ts in England (with the additional inclusion of social services staff among the primary care professionals to whom responsibilities were to be devolved); the other option involved separating purchasers and providers through the respective operational elements of primary care partnerships and provider bodies.

Despite the differences in the proposed organizational configurations, and the time-scales for implementing these, in all four countries much emphasis was placed on the role of primary care (Rummery 1998; Exworthy 2001). This commonality led one commentator to conclude that it was unlikely ‘that Scotland and Wales will develop significantly different models of care from those used in England’ (Owen 1998: 9). Nevertheless, distinct variations can be seen in the organizational templates proposed for the different countries of the UK that reflect their individual political climates (Greer 2001). Moreover, the powers of territorial Parliaments and Assemblies (particularly in Scotland) to make further changes raise questions about the scope of a ‘one-nation’ NHS. In the longer term, devolution may well generate greater spatial variations and reduce similarities across the four countries of the UK. The focus of this book, however, is on the implementation of the NHS reforms in England, to which we now return.

In April 1999, not quite 2 years after Labour came to power, 481 PCGs covering the whole of England went ‘live’. Initially, all PCGs operated at levels 1 or 2. In April 2000, the first 17 PCTs were created, with a further 23 in October 2000 and 164 in April 2001. However, in July 2000, the government unexpectedly re-launched its policy for the NHS with the publication of *The NHS Plan: A Plan for Investment, A Plan for Reform* (Secretary of State for Health 2000). This document, applicable only to England, indicated both the extent of the government’s impatience with the pace of change and its growing enthusiasm for attaching performance ‘strings’ to new investment. *The NHS Plan* signalled further ‘modernizing’ changes, such as the breaking down of traditional professional role demarcations and the creation of new points of access to NHS services. However, it did not fundamentally alter the structure, roles and responsibilities of PCG/Ts. Instead, it contained numerous proposals for performance monitoring, audit and management that would be applied to
PCG/Ts and their constituent elements. The NHS Plan effectively endorsed and elaborated an extensive system of benchmarking and performance management, with sanctions at the end of the line if necessary, in a renewed drive to raise standards and ensure these were met (Paton 2002).

Both The NHS Plan and the publication in 2001 of Shifting the Balance of Power in the NHS (Department of Health 2001) reasserted and strengthened the role of PCG/Ts within the NHS. In the latter policy document, the 1997 intentions of devolving responsibility to locality-based PCGs and PCTs were finally realized. Health authorities, which had continued to support PCGs and manage the performance of PCTs, were to be abolished in April 2002. They would be replaced by a smaller number of strategic health authorities, covering larger areas and responsible for managing the performance of all local NHS organizations, including PCTs. At the same time, all remaining PCGs would become freestanding trusts, regardless of their current level of organizational development. This accelerated organizational transformation allowed the government to claim that by April 2002, 75 per cent of the entire NHS budget for England was devolved to local, primary care-based organizations, governed by doctors and nurses, with responsibilities for securing the provision of a full range of health services for their registered patient populations and for the management, development and integration of all primary care services (Secretary of State for Health 2002).

This organizational restructuring was, therefore, both radical and rapid. Within the history of the NHS as a whole and primary care in particular, the establishment of PCG/Ts has the potential to effect the most far-reaching transformation since its creation in 1948. Primary care groups and trusts constitute a framework within which the primary health services provided by the independent, small businesses of general practice can become part of a single, integrated system of primary care, alongside the larger, more hierarchical organizations of community health services. This does not simply mean that general practice and other non-hospital health services have become part of a single organizational and managerial framework (though this is undoubtedly an important part of the story). Rather (and as the next section of this chapter will show), PCG/Ts were also intended to build on both some of the traditional professional autonomy of general practice and on the experiences of the more entrepreneurial fundholding GPs during the years of the internal market (Ennew et al. 1998). This immediately suggests the potential for tensions to arise between traditional professional clinical freedoms; the extended and enhanced autonomy that had been offered to GPs under the former fundholding regime; and a new organizational framework that provides unprecedented opportunities for more tightly managed modes of planning, organizing and delivering health services, controlling costs and ensuring quality. It also suggests the possibility of tensions arising between local, parochial priorities and concerns and attempts to re-create a strong, well-performing ‘national’ health
service, with all the overtones of equity and inclusiveness that this implies. Additionally, it indicates a potential clash between the rhetoric of devolution and strengthened frontline professional influence and the achievement of national standards through measures such as national service frameworks and tight performance assessment frameworks for PCTs. In other words, any autonomy experienced by PCTs has to be earned (Lee and Woodward 2002). How these various tensions develop and are resolved is crucial to the success of PCG/Ts; they therefore constitute major themes of this book.

Interest in the success of the PCG/T experiment is not just local. Pressures to contain public expenditure, while responding to the twin challenges of globalization and demographic change, are common to other post-industrial societies and prompt searches for new ways to improve the efficiency, quality and accountability of their welfare services. Initiatives by governments that attempt to do this, at the same time as containing the potential escalation of health care costs, are particularly important in this context. As will be shown in Chapter 3, the experiences of PCG/Ts are of wider interest, extending well beyond the shores of the British Isles.

Despite the rhetoric of incoming governments wishing to stamp a new distinctive mark on the institutions and processes they have inherited, substantial elements of continuity with previous administrations and policies are usually apparent. The NHS is no exception to this. Indeed, the rhetoric of The New NHS: Modern, Dependable made a positive virtue out of such continuity, through its stated intention of building on ‘what works’. Thus, despite the White Paper’s outright rejection of the divisive consequences of the internal market and GP fundholding, this immediate past history nevertheless provided an essential foundation on which Labour’s reforms could be constructed. In the next section of this chapter, this history is briefly described. The account will highlight both the negative elements that the incoming Labour government sought to abandon or modify and the positive elements on which it hoped to build.

Background: the problem of general practice and the legacy of the internal market

Two particular policy themes are highlighted here: the experience of the internal market and the role of GP fundholders within this; and the introduction of managerial constraints on the clinical and economic behaviours of independent contractor GPs and the small business-style practices they operated.

The introduction of the ‘internal market’ into the NHS by Margaret Thatcher’s government in April 1991 aimed radically to change a health service in which hitherto hierarchical, ‘command and control’ systems of accountability
had been combined with very considerable professional autonomy (and, therefore, also considerable command over resources) on the part of clinicians. Although GPs did not hold quite such high status as hospital doctors, they nevertheless continued to enjoy a strongly cherished tradition of autonomy and independence (Pater 1981). The internal market sought to reduce the relative power of hospitals and enhance the power of GPs through three main mechanisms. First, the internal market separated the functions of purchasing and providing services; secondly, it introduced competition between providers to improve efficiency; and, thirdly, it built on the traditional ‘gatekeeping’ role of GPs and gave them a greater role in the procurement of local health services (Robinson and Le Grand 1994; Dowling 2000).

The internal market assigned to local health authorities responsibility for purchasing services from hospital and community provider organizations (NHS Trusts). However, an initially small number of individual general practices (GP ‘fundholders’) were allowed to hold delegated budgets with which they could purchase a limited range of hospital services for their patients. During the first half of the 1990s, the range of services that fundholders could purchase was widened and the number of GPs joining the scheme also increased, as initial restrictions on entry were relaxed and new incentives to join were introduced. By the time GP fundholding was abolished in March 1999, around 60 per cent of the population of England were patients of fundholding GPs. Despite the extended coverage of fundholding, however, health authorities maintained responsibility for purchasing most hospital and community health services.

Alongside these two main purchasing arrangements, other hybrid forms developed. A few total purchasing pilot projects, involving large general practices or groups of practices, were given extended budgets to purchase a much wider range of health services than those covered by the standard fundholding scheme. Although one of the main intentions of total purchasing pilots was to extend the opportunities for GPs to exercise purchasing leverage over acute hospital and other health services (NHS Executive 1994), their most marked achievements were in moving resources and services from hospitals to community and primary care, and in developing services based in and around general practice (Mays et al. 1998). Other innovations included multi-funds, in which groups of fundholding practices (rather than individual practices) joined together to purchase hospital and community health services on behalf of all their patients. Meanwhile, in some areas GPs opposed to the principles underpinning fundholding worked together as locality commissioning groups to advise their local health authorities on purchasing decisions, but without any devolution of budgetary control to the group (Regen et al. 1998).

It was from these arrangements that the Labour government’s reforms evolved. In opposition, the Labour Party had remained implacably opposed to GP fundholding (Labour Party 1993), on the grounds that this created
inequities within the NHS and generated expensive bureaucracy and red tape (‘transaction costs’) that diverted resources from direct patient care. Indeed, although much of the early evidence for this assertion was anecdotal, later research did show that fundholding patients tended to have significantly shorter waiting times for access to elective surgery at hospitals (Dowling 1997, 1998). The risk of increased inequities also threatened relationships between primary health and other service providers. For example, some of the total purchasing pilots used their enhanced budgetary flexibilities to improve patients’ access to social services by contributing to the employment of practice-based care managers. However, local authority social services departments were anxious about participating in projects that enhanced access to services for only some of their local populations (Bosanquet 1998).

Labour was faced with a dilemma. Many GPs had become committed to the fundholding scheme (Ham 1996) and abolishing fundholding without giving GPs a central role in any new arrangement could have put the government at odds with an important section of the medical profession, a scenario most administrations would wish to avoid (Dowling 2000). Moreover, the commissioning role of GPs had indeed increased their leverage over hospital services (Klein 1995). There was a growing body of evidence that the purchaser-provider split, including fundholding, had brought some important benefits to the wider NHS, in particular the development of new services in primary care, improved efficiency and savings, and some improvements in access to specialist hospital services (Le Grand et al. 1998; Dowling 2000). From the various GP-dominated purchasing and commissioning arrangements that had developed under the Thatcher and Major governments, Labour therefore saw the potential for commissioning organizations in which GPs had a lead role. It is unlikely that the establishment of PCG/Ts would ever have been considered had it not been for the experience of the internal market and GP fundholding (Dowling 2000).

This experience provided the empirical justification for the incoming government’s rhetoric of building on what works. Moreover, given continuing pressures to contain costs, there was no rationale for returning to a situation where GPs could make clinical decisions without also taking responsibility for their financial consequences. This can be seen as part of a longer-term trend across the public sector as a whole, in which market mechanisms are increasingly used to harness professional decision-making to financial controls (Clarke and Newman 1997). A major circle that the new Labour government attempted to square through the creation of PCG/Ts was the abolition of GP fundholding, while at the same time ensuring that GPs retained a major role in systems of resource allocation and cost control.

The creation of PCG/Ts was not the only mechanism available to the incoming government to bring about change in the English NHS, although it was certainly the most extensive and radical. Two other levers, both of which
had been used by previous administrations, also had the potential to transform traditional modes of providing primary and community health services. One was the introduction of an alternative to the traditional GP contract. Even the previous Conservative government had become increasingly concerned about the wide variations in the range and quality of primary health services that had been further exacerbated by GP fundholding. The individualistic culture and existing contractual framework of general practice provided little opportunity for NHS managers to intervene to improve equity, quality or service integration. Moreover, consultation with grassroots health professionals revealed demands by GPs for greater flexibility and diversity of employment arrangements; to these arguments were added concerns about an impending crisis in the primary care workforce supply. The 1997 NHS (Primary Care) Act, passed just before the May general election, therefore introduced for the first time an alternative to the traditional GP contract – the personal medical services contract. This offers the opportunity for the much tighter contractual specification of primary care services. This might involve the targeting of services at particular areas or population groups (for example, homeless people or ethnic minority groups) for whom provision is currently poor. Personal medical services contracts can include specified standards of services. They also offer opportunities to introduce greater flexibility between the roles and responsibilities of GPs, nurses and other health professionals. Personal medical services schemes have proved popular with NHS managers and GPs alike – for the latter, they offer opportunities for more flexible salaried employment arrangements. Since April 2002, personal medical services contracts have been held by PCTs, thereby allowing PCTs to direct primary care services to disadvantaged neighbourhoods or patient groups within their locality. Furthermore, the 1997 Act laid the ground for the integration of the previously separate funding streams for GP and other community and hospital services, which was later completed through the creation of PCG/Ts.

The other mechanism that has the potential to bring about widespread changes, especially in the balance between managerial and professional interests, is the changing nature of the contract under which GPs provide general medical services to the NHS. A new contract was imposed on GPs in 1990, which, for the first time, specified minimum standards of service and tied some elements of GPs’ remuneration more closely to the provision of certain services. During 2001, discussions began between the profession’s leaders and the Department of Health about a revised contract – with GP practices rather than individual practitioners – that would include major new incentives to improve the quality of primary health care, as reflected in clinical processes, patients’ experiences and the internal organization of practices. Under the proposed new contract, a very substantial proportion of GPs’ income could be linked to the attainment of quality targets (depending on the number and complexity of these targets and the level of financial incentives on offer). The
new contract is also likely to include the flexibility for individual practices to opt in or out of providing particular services, subject to negotiation with their PCT (NHS Confederation 2002). A new GP contract, therefore, has the potential to strengthen dramatically the managerial levers available to PCTs, especially in relation to their responsibilities for clinical governance (see Chapter 7).

**The challenges of judging ‘success’ in the modernized NHS**

The ambitiousness and complexity of the Labour government’s objectives for primary health services make evaluation difficult. However, the government itself has highlighted the importance of evaluation and related research activities, through its promotion of evidence-based policy and practice. Indeed, the 1997 White Paper opened with the pragmatic dictum that ‘what counts is what works’ (Secretary of State for Health 1997: 10). Commentators have pointed out that the promotion of evidence-based policy-making is far from new (Harrison 1998; Nutley and Webb 2000). However, both what counts as evidence and the creation and implementation of policies based on ‘evidence’ are invariably equivocal and contested. Certain kinds of evidence tend to be privileged over others, especially quantifiable evidence that is readily and quickly available and is employed within a positivist paradigm. Klein (2000) has drawn attention to the ‘attempt by the EBM [evidence-based medicine] movement to privilege certain types of evidence, notably the results of randomized trials, over other kinds of knowledge or understanding. The former is “science”; the others are not’ (p. 65). This trend is, arguably, reinforced by the growing need for evidence that can underpin managerial strategies for regulating and improving performance (Ferlie et al. 1996). In contrast, ‘evaluation of organizational reconfigurations or models of service delivery is methodologically more uncertain, less rigorously executed or frequently omitted’ (Davies and Nutley 2000: 59). Moreover, Klein (2000) argues that the attempt to derive and apply the same evidence-based paradigm to policy-making rests on a ‘gross misunderstanding of the policy process, as well as on an exaggerated claim about what research can deliver’ (p. 65).

Policy innovations are themselves modified in the course of implementation, which can often extend over a considerable period. Organizational reconfigurations take time to achieve; changes in the roles, behaviours and attitudes of frontline healthcare staff and other professionals may also be required and these are likely to take even longer. Detecting change over a relatively short time-scale, when some of these changes are still incomplete, can therefore be difficult. For example, policies and practices that aim to improve population health or reduce health inequalities are likely to involve long-term programmes, the impact of which may not be detectable for up to a
generation; more immediate process measures may need to be used instead (Exworthy and Berney 2000).

Furthermore (and leaving aside the impact of other levers for change, such as personal medical services contracts), the establishment of PCG/Ts, the objectives they are required to achieve and the variety of methods that are likely to be employed in addressing those objectives together make up a multi-faceted and highly complex programme of change. Success in one area (for example, reducing inequalities in access to primary care services) may be accompanied by failure to meet targets in another (for instance, reducing waiting times for hospital appointments and treatments). It may not be feasible, either practically or theoretically, to weigh up these different outcomes against each other. Evaluating complex programmes of change also generates difficulty in attributing causality. ‘When a particular effect or impact is identified, how can the evaluator decide which reform facet or component produced it?’ (Pollitt 1995: 139).

A further question is that of the criteria against which ‘success’ should appropriately be measured. Powell (2002) makes the important distinction between intrinsic and extrinsic evaluation: ‘The former is based on assessing progress in terms of the government’s own stated objectives . . . The latter examines a standard set of evaluation criteria, irrespective of a government’s stated objectives’ (p. 4). Intrinsic evaluation is therefore based on comparing stated aims and objectives with achievements, while extrinsic evaluation involves some external reference point (which may be different from the government’s own objectives and, indeed, may not be accepted as legitimate by government).

As the contributions to this book will describe, in the short time since PCG/Ts were created, they have been set an extremely challenging programme of extensive and rapid organizational and cultural change. Each of the three original core functions of PCG/Ts (improving health, developing primary and community health services, and commissioning specialist health and other services) could itself be broken down into numerous smaller, or interim, goals and targets. These might also embrace less tangible objectives, such as involving frontline health professionals in all areas of strategic decision-making, engaging with local publics and communities, or working in partnership with other organizations. Actions that are directed towards one particular objective may also, indirectly or directly, contribute towards the achievement of others. For example, the appropriate commissioning of health services by PCG/Ts may also contribute towards reducing health inequalities (or, at least, reducing inequalities in experiences of health care). Conversely, some goals, and the management of performance towards achieving them, may be incompatible, or at least risk creating tensions and ‘perverse incentives’. For example, enhancing the role of frontline professionals in decision-making is likely to highlight particular local needs and priorities and these may conflict with the
re-creation of a one-nation NHS. Eventual outcomes are therefore likely to be
long-term, multiple and potentially contradictory.

The contributors to the remainder of Part 1 of this book focus on some of
the wider implications and challenges prompted by the ‘new’ NHS. Together,
they set the Labour government’s reforms within a broader context and offer
a range of extrinsic criteria and analytic frameworks within which the empir-
ical evidence presented in Part 2 can be located and interpreted. In Chapter 2,
Bond and Le Grand discuss the potential for using a mix of hierarchical
and market mechanisms which are associated with the ‘Third Way’ to achieve
change in health care and services. In Chapter 5, Croxson, Ferguson and
Keen address the theme of transforming relationships between professionals
(particularly GPs), and between professionals and users of health services.
Implicit in both chapters are the potential tensions between professional
authority and autonomy (and the consequent structuring of relationships
with patients) and the new forms of managerial accountability that profes-
sionals are also expected to incorporate into their own behaviours. In Chapter
4, Baker describes some of the challenges likely to be experienced by PCG/Ts in
improving the health of local populations and in demonstrating such
improvements. In Chapter 3, Robinson locates the English PCG/T experiment
within an international context; as perhaps the most ambitious and complex
organizational integration of primary care in developed economies, its out-
comes will be awaited with interest.

The chapters in Part 2 of the book present detailed evidence on the oper-
ation of PCG/Ts in relation to their main objectives. The focus in each chapter
is on the barriers and opportunities that are likely to affect the success, or
otherwise, of these new organizations. Thus in Chapter 6, Dowling, Wilkin
and Smith evaluate the development of PCG/Ts’ organizational capacity and
their management of the new, integrated budgets. In Chapter 7, Campbell and
Roland assess the strategies used by PCG/Ts to implement clinical governance
and reflect on the likely effectiveness of these strategies. Most of the responsi-
bilities with which PCG/Ts are charged depend on the effective use of informa-
tion management and technology (IM&T), a subject that Jones and Wilkin
examine in Chapter 8. Chapter 9, by Dowling and Wilkin, explores how
far PCG/Ts have been able to build on the experience and successes of GP
fundholding in commissioning hospital services. Chapters 10, 11 and 12 take
a slightly broader perspective of PCG/T activities, focusing respectively on
activities to improve health and reduce health inequalities; the involvement
of local communities and the general public in the decision-making of PCG/
Ts; and PCG/Ts’ ‘partnerships’ with other statutory, voluntary and private
organizations.

Most of the chapters in Part 2 draw on data from the National Tracker
Survey of PCG/Ts, a longitudinal survey of PCG/Ts carried out between 1999
and 2002 at the National Primary Care Research and Development Centre at
the University of Manchester (Wilkin et al. 1999, 2001, 2002). The Tracker Survey was originally based on a representative sample of 15 per cent (72) of PCG/Ts (some subsequently merged). Three separate ‘sweeps’ of the survey were carried out, approximately 6 months, 18 months and 3 years after PCG/Ts came into being. The fieldwork for the first ‘sweep’ involved interviews with PCG chief officers, chairs and health authority leads; and postal questionnaires to clinical governance, prescribing, IM&T leads, social services representatives on PCG boards, and other GP and nursing board members. Fieldwork for the two subsequent ‘sweeps’ of the Tracker Survey followed the same pattern, although the face-to-face interviews were replaced by telephone interviews.

Large and complex surveys of this kind have their limitations, especially in the level and depth of detail they are able to collect. However, the Tracker Survey provides a unique picture of a process of major organizational development from the different perspectives of several key stakeholders. Being able to offer a multi-faceted, pluralistic account is a major strength in research on complex organizational change and this will, we hope, also be reflected in the remainder of this book.

References

INTRODUCTION


