

Primary care led commissioning in England and Wales: the changing complexity of governance for quality, 1991-2005.

Data archive: background and structure

This research explored primary care-led commissioning (PCLC) in the NHS in England and in Wales, and to set these in the context of NHS changes since 1991. PCLC is understood here to mean the process of arranging the whole range of health care services (acute, community, primary), either by providing services directly or by commissioning them from other providers. There were five key objectives:

1. To explore the extent to which the complexity and bureaucratic nature of governance processes enable Primary Care Trusts (PCTs; in England) and Local Health Boards (LHBs; in Wales) to pursue strategic and clinical objectives relating to service quality.
2. To discover how PCTs/LHBs and the disparate groups within them manage and negotiate the demands of governance mechanisms on organisational capacity.
3. To assess which governance mechanisms have most (and least) 'bite' and influence on service quality, and why.
4. To discover whether these governance arrangements permit 'bottom-up' innovation and encourage clinical and managerial commitment to quality.
5. To interpret the findings in the light of between-country differences (England and Wales) and changes in the NHS since 1991.

The study comprised a literature review; three in-depth case studies, two English PCTs and one Welsh LHB; and an analysis of PCT/LHB documents published on the Internet.

Case study sites

The case studies comprised semi-structured interviews (tape-recorded and transcribed) with directors, officers and clinicians working at the sites. Data gathering took place from summer 2005 to spring 2006. A summary of findings at each site was sent to those interviewed for comment, updating and correction. All transcripts were

checked against the tapes by the principal investigator, and have been anonymised. Questions appear in bold type.

The first site was a Welsh LHB (LHB1) and serves a prosperous rural and country town population of about 93,000 (largely white British). The second was a PCT serving a London borough (PCT1) with a total population of about 300,000 including considerable socioeconomic and ethnic diversity. The third was a PCT (PCT2) serving two out of the three towns in a borough on the edge of a metropolitan area in northern England, with a population of about 78,000, deprived and almost exclusively white British.

Documentary analysis

The following documents, as published on PCT and LHB websites, were analysed:

- board meeting minutes
- accompanying papers, including regular reports (e.g. clinical governance, patient complaints, etc.)
- minutes/reports of Professional Executive Committees (PECs; in PCTs only, these do not exist in LHB).

A stratified random sample of 15 primary care organisations was drawn up, 10 PCTs and 5 LHBs, in accordance with the criteria set out in the matrix below.

<i>Type of organisation</i>	<i>Geographical location</i>	<i>Nature of community served</i>
PCT	North of England	Metropolitan
		Urban
		Rural
	Midlands	Metropolitan
		Urban
		Rural
	South (excluding London)	Rural
		Urban
	London	Inner London
		Outer London
LHB	North	Rural
		Urban
	South	Cardiff
		Rural
		The Valleys

All relevant board meeting documents for 2005 were analysed, using a data extraction grid which was first piloted.

Structure of archive

The archive consists of two main sections, each including three sub-sections, as follows:

Interview data

Transcribed interviews from:

- LHB1
- PCT1
- PCT2

Documentary data

Grid 1: board papers of 5 LHBs in Wales

Grid 2: board papers of 10 PCTs in England

Grid relating to PEC papers of 10 PCTs in England

RES-000-22-1198 – Primary Care-Led Commissioning in England and Wales – the Changing Complexity of Governance for Quality, 1991 - 2005

An influential interpretation of the recent history of public sector management has it that relatively flexible forms of governance such as markets and networks have begun to eclipse more rigid and cumbersome hierarchical forms. Whereas hierarchies organise activity by means of authority, networks see groups co-operating for mutual interest, whilst markets organise activity by the accumulation of market decisions.

This study assessed the relevant importance of each of these governance mechanisms in the commissioning and provision of hospital-, community- and GP-based health care from 1991 onwards, with a particular focus on their effects on service quality.

Key Findings

Concentrating on the experiences of three primary care organisations (PCOs), the study found that whilst the NHS now uses a wider variety of market and network mechanisms, the dominant strategic governance mechanism remains upward hierarchical accountability to national government.

Hierarchies

PCOs are upwardly accountable to central or devolved government with nationally-driven performance management the major strategic governance mechanism, which leaves little room for local priority-setting. They are also upwardly accountable to their boards. Boards have high levels of trust in PCOs, and also provide useful challenge. Internally, PCOs manage their own employees, which is taken for granted.

Markets

General practitioner fund holding (GPFH) and its variants (1991-1999) were the sole instance of markets operating strategically, and are generally regarded as successful. Purchasing contracts were detailed and closely monitored, and drove changes in services.

However, current market mechanisms are considered weak with respect to purchasing hospital services, with service level agreements lacking detail and not monitored for quality-related issues.

The quality and outcomes framework (QOF) in the new GP contract aims to reward high quality general practice, and is considered useful.

Networks

Bringing clinicians from hospital and primary care settings together is considered an effective way of redesigning services and securing 'buy-in', whilst collaboration with other PCOs is stimulated by the need for combined strength or purchasing power when buying hospital services.

Whilst such inter-organisational 'external' alliances are voluntary, PCOs themselves are formally structured 'internal' networks. Attitudes to the ease and effectiveness of external collaboration varied amongst PCO staff, whilst the necessarily bureaucratic practices of PCOs had, in turn, alienated many GPs.

The new GP contract requires PCOs to have close links with GP practices, although officers had tried to 'facilitate and support' rather than 'police' due to the reluctance of GPs to accept PCO monitoring. Many GPs considered PCOs to be, in essence, 'hierarchical-bureaucratic interference', and clinical governance to be more concerned with procedure than service quality.

About the study

The project was led by Stephen Abbott of the Public Health and Primary Care Unit at the City University Institute of Health Sciences. Part of the ESRC 'Public Services: quality, performance and delivery programme', the study was based upon 48 interviews with key personnel at three primary care organisations (PCOs), a documentary analysis of the board papers for 2005 of 15 PCOs, and a literature review.

Key Words

Primary care, governance, service quality.

ACTIVITIES AND ACHIEVEMENTS QUESTIONNAIRE

1. Non-Technical Summary

A 1000 word (maximum) summary of the main research results, in non-technical language, should be provided below. The summary might be used by ESRC to publicise the research. It should cover the aims and objectives of the project, main research results and significant academic achievements, dissemination activities and potential or actual impacts on policy and practice.

Primary care-led commissioning in England and Wales: the changing complexity of governance for quality, 1991-2005.

Introduction

An influential narrative of recent public sector management describes how market and/or network forms of governance have begun to eclipse hierarchical forms. Hierarchies are seen as inflexible, networks and markets as less rigid and cumbersome. Hierarchies organise activity by means of authority; networks are self-organising groups co-operating for their mutual interest; and the 'invisible hand' of the market organises activity not by strategic deliberation but by the self-adjusting accumulation of individual market decisions.

In this report, 'commissioning' means the arranging of all types of health care: not only the purchasing of services from health care providers, but also the direct provision of services.

Reforms to the United Kingdom National Health Service (NHS) illustrate this narrative. The introduction of the 'internal market' in 1991 replaced the previous hierarchical arrangements for commissioning health care. An important element of the internal market was general practitioner fund-holding (GPFH), which allowed general practices to purchase a range of hospital and community health care for their patients. The creation from 1999 of Primary Care Organisations (Primary Care Groups and Trusts in England, and Local Health Groups and Boards in Wales) was an attempt to address the limitations of the internal market. To further strengthening commissioning in England, additional market mechanisms are now being introduced.

This study looks at primary care-led commissioning from 1991 onwards in England and Wales, and assesses the relative importance of hierarchy, network and market as governance mechanisms. Service quality is the focus, rather than corporate governance, finance, and other 'back office' functions. Both strategic and tactical levels are considered. The *strategic* level refers to how the direction of the NHS is determined; at the *tactical* level, governance methods are primarily implementation mechanisms.

PCOs purchase most hospital-based health care and provide most primary health care (general practitioners, dentists, pharmacists, optometrists), and provide (in England) or purchase (in Wales) community health care. Most GPs are independent contractors, working alone or in partnerships.

The study was based on forty-eight interviews with key personnel at three PCOs (two

PCTs and one LHB), a documentary analysis of the board papers for 2005 of fifteen PCOs, and a literature review.

Findings

Note: few differences between England and Wales emerged from the data.

Hierarchies

There are various hierarchies relevant to PCOs. First, they are upwardly accountable to the Department of Health or Welsh Assembly Government. It was clear that nationally driven performance management (including the use of targets and performance indicators) was the major strategic governance mechanism. This dominated activity and left little room for local priority-setting.

Second, they are upwardly accountable to their PCO boards. Generally, PCO boards had high levels of trust in PCOs. There were instances of challenge from the boards, and their ability to question, whether used or not, did influence officers in their decisions, reports, etc.

Third, they manage their own employees. Internal hierarchies attracted little comment from informants, reflecting the degree to which this arrangement is taken for granted in most organisations.

Markets

GPFH and its variants were the single instance of markets operating strategically. GPFH was generally regarded as very successful: purchasing contracts were detailed and closely monitored, had successfully levered many service changes, and influenced NHS development locally.

Current market mechanisms were regarded as weak with respect to purchasing hospital services. Current service level agreements lacked detail, and were only monitored for activity levels and cost, not quality-related issues. Some small successes in using market mechanisms were reported.

The new GP contract allows the local purchasing of services from GPs, and may thus be regarded as a market mechanism. The quality and outcomes framework (QOF) in the new contract aims to reward high quality general practice, and informants saw it as generally useful.

Networks

Networks may be divided into inter-organisational (external) and intra-organisational (internal). External networks consisted primarily of collaborative working with hospital services providers, other PCOs, and local government. All three sites were involved in strategic planning about the changing configuration of hospital services.

Bringing clinicians from hospital and primary care settings together was an effective way of re-designing specific services and securing 'buy-in' by relevant parties. Collaborations with other PCOs were stimulated by the need for combined strength and/or for economies of scale when purchasing hospital services. All three sites showed evidence of collaboration with local government: jointly commissioned services, jointly provided services, and/or joint appointments.

Such inter-organisational alliances are voluntary relationships rather than formal organisational structures. By contrast, PCOs internally are compulsory and formally structured networks. 'Buy-in' to this collaborative approach was variable among PCO personnel. It was clear that the bureaucratic activity of PCOs, unavoidable in statutory bodies, had alienated many GPs.

Administering the new GP contract required PCOs to have close links with practices. Because of the reluctance of many GPs to accept PCO surveillance, officers tried to avoid a 'policing' style, preferring to describe their role as one of facilitation and support. For many GPs, PCOs were a thinly disguised form of hierarchical-bureaucratic interference with small businesses. They tended to see clinical governance more as a set of procedures designed by officers than as a stimulus to clinicians themselves to develop and maintain quality services.

Conclusion

At the tactical level, the NHS now uses a wider variety of market and network mechanisms than prior to 1991. However, there is no doubt that the dominant strategic governance mechanism continues to be upward hierarchical accountability to national government, and that, with the time-limited exception of GPFH, market and network mechanism have not been strong enough to challenge the direction set hierarchically.

Thus, the narrative that public sector management has witnessed the yielding of hierarchy to market and network is not borne out in the case of the NHS. A wider repertoire of tactical mechanisms has become available, but strategically, hierarchical governance continues to predominate.

Primary care-led commissioning in England and Wales: the changing complexity of governance for quality, 1991-2005.

1. Introduction

An influential narrative of how public sector management has developed in the last twenty years describes how market and network governance has begun to eclipse hierarchical governance (Hoggett, 1996; Kickert et al, 1997). Hierarchy is a way of organising activity by means of authority, and usually involves reliance on explicit rules (bureaucracy). Networks are self-organising groups of people and organisations who co-operate for their mutual interest. The ‘invisible hand’ of the market organises activity, not deliberately, but by means of the self-adjusting accumulation of countless individual market decisions (Thompson et al, 1991).

In the hierarchy/market/network narrative, hierarchies are seen as being inflexible, slow to adapt, and unresponsive to the needs and wishes of those who use public sector services (Bevir, 2003). Networks and markets are portrayed as less rigid and cumbersome and markets, in particular, as more responsive to service users.

The succession of reforms to the United Kingdom National Health Service (NHS) appear to illustrate this narrative very aptly. The introduction of the ‘internal market’ in 1991 replaced the previous hierarchical arrangements whereby local health authorities directly managed hospital services. The creation at the end of the 1990s of Primary Care Groups and Trusts (PCGs and PCTs) in England, and Local Health Groups and Boards (LHGs and LHBs) in Wales, can be seen as the deliberate creation of networks to address the limitations of the internal market (Secretary of State for Health, 1997). A number of new market mechanisms are now being introduced in England, though not Wales, to address the limitations of networks. There are good arguments for seeing the NHS as having been from its inception a varying mixture of quasi-hierarchy, quasi-markets and quasi-networks (Exworthy et al, 1999). For the sake of elegance, ‘quasi’ is omitted throughout but should be taken as understood: NHS forms are by no means ‘pure types’.

A parallel and compatible narrative highlights the ‘hollowing-out’ of the state (Rhodes, 1997), whereby governments no longer directly control public sector services. These are provided by a variety of independent or semi-independent organisations, while government continues to set the strategic direction and monitor services against centrally set standards: ‘rule at a distance’ (Rose, 1999). Such rule is still essentially hierarchical, though the organisational forms of hierarchy may change: in the period studied here, there was a considerable flattening of the structure of the NHS as levels of hierarchy between central government and health care organisations were reduced (DH, 2001).

This study looks at governance at two levels. At the *strategic* level, it refers to how the direction of the NHS is determined: for example, the National Service Framework for Coronary Heart Disease specifies the range of services which should be universally available; cancer networks are charged with organising services across PCOs, general and specialist hospitals. At the *tactical* level, governance methods are primarily implementation mechanisms at a local level: if a PCT officer wants to commission a particular service, does s/he set up a contract with an outside service provider, provide the service in-house, or set up a steering group to develop an inter-agency collaboration?

This report assesses the relative importance of hierarchy, network and market as governance mechanisms in primary care-led commissioning from 1991 onwards, looking at both strategic and tactical levels. Service quality is the focus, rather than corporate governance, finance, and other ‘second order’ functions (Exworthy et al, 2003); the governance activity of interest is that which is concerned with the design and maintenance of appropriate health care services to patients. It includes both England and Wales. It deliberately excludes the new market mechanisms being introduced in England at the time of data gathering (Payment by Results, Choose and Book, Practice-based commissioning), as they had not had time to take effect.

We use ‘commissioning’ in a broader sense than its current NHS usage. Here, commissioning means the arranging of all types of health care: not only the purchasing of services from health care providers, but also the direct provision of

services. Commissioning is currently used in the NHS to denote what was formerly called 'purchasing', and this older usage is preserved here for the sake of clarity.

The structure of the report is as follows. First, a more detailed account of the cycle of reforms is provided. Second, the methods used in the study are briefly described. Third, the chief findings are outlined and illustrated.

2. *Background*

An internal market was created in the NHS in 1991. Local health authorities became the principal purchasers of health care, while the simultaneous introduction of general practitioner fund-holding (GPFH) gave individual general practices of a certain size the opportunity to purchase a limited range of health care for their patients. Over the next six years, this model was adapted and extended. Most notably, Total Purchasing allowed pilot sites to purchase all acute and community care, although in practice they purchased only a limited range (Mays et al, 2001).

The Labour government announced in 1997 that the internal market would be radically reformed over ten years, although the principle of primary care-led purchasing of hospital care would be maintained (Secretary of State for Health, 1997). In England, geographically-based primary care groups (PCGs) brought together GPs who provided primary care; PCGs were expected to advise health authorities on purchasing hospital and community health care. PCGs could choose to become primary care trusts (PCTs). PCTs then became compulsory, and are now expected to commission almost all health care on behalf of their populations:

- most hospital-based health care provided by NHS trusts;
- community and primary health care provided by PCTs;
- primary health care provided by independent practitioners (general practitioners, dentists, pharmacists, optometrists) working within the PCT.

Although three kinds of health care have been distinguished (hospital services, community health care and primary care), there is considerable potential for service substitution between the three categories.

Developments in Wales have been broadly similar, despite the devolution of some national government functions to the Welsh Assembly Government in 1999. Local Health Groups (LHG) and Local Health Boards (LHB) were and are the equivalent of PCGs and PCTs. There are nevertheless significant differences between the Welsh and English health care systems:

- community health care is purchased by LHBs and provided by integrated NHS trusts that also provide hospital care;
- the ethos of the Welsh NHS is orientated more to a public health and local partnerships approach;
- the new purchasing mechanisms being introduced in England are not being replicated in Wales.

A further difference is that PCTs but not LHBs include Professional Executive Committees (PECs) consisting of senior managers, GPs, and nurse and social services representatives. PECs are designed to ensure clinical input into PCT decision-making. However, LHB boards are much larger, and include more clinicians than do PCT boards.

Henceforth, the term Primary Care Organisations (PCOs) will be used to refer to PCTs and LHBs together when the differences between them are not pertinent.

Since the inception of the NHS, GPs have generally worked as independent contractors, alone or in partnerships: a single standardised national contract between each GP or partnership and the Department of Health (DH) specified GPs' responsibilities. Such contracts have become less standardised over time, with the increasing use of locally negotiated agreements. First, Personal Medical Services (PMS), introduced in 1997, allowed local variations to the national contract to meet local needs as agreed with health authorities. Second, the DH introduced in 2004 a new GP contract, to be administered by PCTs. This offers opportunities to PCTs and GPs to support improvements in the quality of general practice, and to use primary care to provide services formerly provided by hospital or community health care. There is scope for much more local variation in services provided by GPs, to be

negotiated by GPs and PCOs. PCOs also manage new contracts with dental practitioners, pharmacists and optometrists.

Table 1 captures some of the changes in the three types of commissioning which have resulted from changes in the NHS since 1991.

Table 1. Changes in commissioning, 1991-2005.

<i>Commissioning:</i>	<i>GPFH (1991-9)</i>	<i>TP (1995-9)</i>	<i>PCGs/LHG</i> s	<i>PCT</i> s	<i>LHB</i> s
	<i>Voluntary, partial coverage of population</i>		<i>Compulsory, universal coverage</i>		
<i>Acute health care</i>	Could purchase some	Could purchase all	Could advise on purchasing	Must purchase all	Must purchase all
<i>Community health care</i>	Could purchase some	Could purchase all	Could advise on purchasing	Must provide all	Must purchase all
<i>Primary health care</i>	GPs provide	GPs provide	GPs and/or PCGs provide	GPs and/or PCTs provide	GPs and/or LHBs provide

All NHS organisations in England and Wales work within a hierarchical framework of accountability to the Department of Health and the Welsh Assembly Government respectively. These set national targets and specify policies and requirements. PCOs are required to follow the recommendations of the National Institute for Health and Clinical Excellence (NICE) and National Service Frameworks, and are inspected by the Healthcare Commission. Although central policies may be quite broad and leave room for local choices about implementation, they can also be quite specific, requiring that particular treatments be available (NICE guidance, for example), or that specific delivery mechanisms are in place (for example, the new role of ‘community matron’). Throughout this period, governments have emphasised the need for the NHS to become more responsive and accountable to the patients and the public, and the Labour Government introduced a number of new structures and processes for this purpose, intended to strengthen the role of patients and the public in the NHS ‘policy network’ (Rhodes, 1997).

3. *Aims and methods*

The aim of this research was to explore the purchasing and provision of health care from primary care in England and Wales since 1991, examining in particular which governance mechanisms help to maintain and improve the quality of health care. The

study comprised a literature review, three qualitative case studies of PCOs, and a documentary analysis of a sample of PCO board papers.

The case study sites were two English PCTs, one in London (PCT1), one in the north of England (PCT2), and one Welsh LHB (LHB1). Semi-structured interviews were carried out with stakeholders, and were recorded, transcribed, and analysed using NVivo. A summary of findings at each site was prepared and sent to those interviewed for comment, correction and updating. It had been intended to use e-mail to gather reflections on the data from an electronic reference group. However, response rates were so low that this strategy was abandoned. The purpose of the case study approach was to illuminate changes in NHS governance by exploring the experience of those working within PCOs, inviting them to reflect on both the current NHS and the changes experienced during the course of their NHS careers. Such perspectives may be very different from those of outside analysts.

The documentary analysis looked at the board papers for 2005 of ten PCTs and five LHBs (stratified random samples reflecting metropolitan, urban and rural PCOs across Wales and England). A data extraction grid was compiled, including both tick-box and free-text entries. The former were summarised numerically; free text data were analysed thematically.

4. Results

The following account of results is based on case study data, but informed throughout by the results of the documentary analysis and literature review.

4.1 Case study sites

PCT1 serves a London borough with a population of approximately 300,000; it is a socio-economically diverse population with very high numbers of minority ethnic groups. There is a large number of single-handed GPs (unlike the other two case study sites). About a third of practices were formerly GP fundholders. There was also an officially designated Locality Commissioning Pilot within the borough, which became a PCG in 1999, one of three which later joined to become a PCT.

PCT2 serves two towns on the edge of a metropolitan area in the north of England. It works closely with a neighbouring PCT; together, they serve one metropolitan borough. The PCT's population is approximately 78,000; it is a deprived population, with low numbers of minority ethnic groups. The level of GP fundholding was high. GPs locally supported an early move to PCT status in order to maintain the profile of the two towns, which believed themselves to be marginalised by their larger neighbour.

LHB1 serves a Welsh county with a population of approximately 93,000, including some who live in England. It is a rural area with a number of towns, and is regarded as prosperous and healthy. GP fundholding was universal in the county, and there was a county-wide total purchasing pilot.

Table 2. Interviewees at the three sites

	<i>PCT1</i>	<i>PCT2</i>	<i>LHB1</i>
<i>Interviews took place:</i>	Jan-May 2006	Aug- Dec 2005	July – Dec 2005
<i>People interviewed:</i> Board members	Chair Chief executive Non-executive director PEC chair	Chair Chief executive PEC chair	Chair Chief executive Non-officer member 4 officers 4 clinicians
Others:	7 officers 3 PEC members Practice manager	7 officers 2 PEC members GP Chair of PPIF*	6 officers 2 GPs
Total interviewed:	15	14	19

* Patient and Public Involvement Forum

Unexpectedly, few differences between England and Wales were apparent in the data, despite policy and structural differences between the two countries. Differences are likely to increase in the future as market mechanisms are introduced in England but not Wales. The two PCTs in the study, though very different in size, population and local context, nevertheless generate data which support similar generalisations.

4.2 *Hierarchies*

There are various hierarchies relevant to PCOs:

- they are upwardly accountable to the Department of Health or Welsh Assembly Government;
- they are upwardly accountable to their PCO boards;
- they manage their own employees.

4.2.1 *Accountability to government*

It was clear that nationally driven performance management (including the use of targets and performance indicators) was the major strategic governance mechanism. This dominated activity and left little room for local priority-setting. Strong government steering can be helpful in that it gives different organisations a common interest; thus, PCOs and hospital providers cooperate to reduce waiting times, since they are both judged by these. And there was no quarrel with the importance to patients and services of many of the government's priorities. Nonetheless, informants appeared more burdened than supported by the number of top-down directives. The sheer number of government targets and policies limited the usefulness of each: although intended to support quality improvement, they were often also distractions or barriers. LHB1 informants were agreed that the Welsh Assembly Government had initially been less directive than the Department of Health, but felt that pressure from the centre had become much stronger recently.

The acceleration of NHS reform in England imposed by the Department of Health was also seen as an impediment to the work of PCTs. Structurally, the period 1991-2005 saw a considerable reduction in the number of layers between central government and front-line services, but if anything, this had increased the sense of strongly centralised direction.

4.2.2 *PCO boards*

Although PCO boards are theoretically tasked with setting strategy, everyone agreed that most strategy is pre-determined centrally. Furthermore, since there are extensive national monitoring and inspection regimes, the value of boards' monitoring function is not obvious.

Generally, boards had high levels of trust in PCOs. There were instances of challenge from the boards, and their ability to question, whether used or not, did influence officers in their decisions, reports, etc. But for much of the time, boards' influence was felt less as a direct accountability mechanism and more as one of a network of groups within the PCO which together influence decisions and activity. Board members often sit on committees and subcommittees, which together gradually take forward PCO work by means of negotiation and discussion. LHB boards are large (28 members) and include a wide range of stakeholders, thus symbolising a partnerships approach. The greater numbers may mean that it is harder to get consensus: more LHB boards voted than PCTs. In general, however, board votes were rare, confirming the impression of consensus rather than of dissent.

Board meetings tended to give more time to 'back office' functions (finance, organisational structures, and so on), though they did give some attention to service quality and clinical issues.

4.2.3 Internal hierarchies

Internal hierarchies attracted little comment from informants, and no problems were articulated. This probably reflects the degree to which this arrangement is taken for granted in most organisations. PCT1 had recently introduced an internal purchasing process for directly provided services, rather than relying on hierarchy alone. In all three sites, the new GP contract enabled PCOs to purchase from local GPs new community health services, which might previously have been provided directly (England). Thus, hierarchy became somewhat less dominant in arranging community health services.

Accountability requirements as implemented within PCOs sometimes felt unduly bureaucratic: clinical governance, a national requirement, tended to be seen more as a set of procedures designed by officers to avoid risk than a stimulus to clinicians to develop and maintain quality services.

In summary: the external hierarchical power of central government was seen as the dominant strategic governance mechanism of the NHS.

4.3 Markets: contracts and service level agreements

GPFH and its variants were the single instance of markets operating at strategic level: the accumulation of decisions by small-scale purchasers had determined the direction of NHS development locally, albeit in limited fashion. GPFH was generally regarded as very successful: contracts were detailed and closely monitored, and had levered many service changes. Its success was also due to the fact that its scale was small: purchasers could ‘irritate’ providers to make changes without destabilising them. However, the range of services included had been limited, and, as many GPs did not participate, inequity across the NHS increased. It was also noted that GPFH flourished because it received more government subsidy than did health authority purchasing.

Market mechanisms were regarded as currently weak with respect to purchasing hospital services. No-one believed that current service level agreements were effective, being no more than ‘block contracts’, lacking in detail, and monitored for activity levels and cost only, not quality-related issues. In this they resembled health authority contracts at the time of GPFH, which were also ineffective. In the hospital sector, there was considerable though not universal resistance to change, and PCO personnel could only improve hospital services on a small scale and by painstaking negotiations with hospital staff to change ‘hearts and minds’. This was very different from the rapid responses which GPFH had elicited from providers by detailed contract monitoring or threatening to remove contracts.

Some success in using market mechanisms was reported. PCT2 had eventually managed to negotiate with a large mental health services provider to withdraw its investment, which was disproportionate to services received. LHB1 did purchase some services on a small scale from other providers, particularly in England, where waiting lists were shorter. But it felt it had limited scope to move a lot of work away from its main provider, not wishing to destabilise an organisation already struggling to improve its performance. Whereas GPFH had generally taken money out of existing contracts to pay new providers, PCOs were unable to do so, as providers were apparently unable to identify or release the relevant funds.

Informants also mourned the loss of that clinical contact between GPs and hospital doctors which had characterised GPFH. Such contact had had a real impact on service quality in purchased services. GPFH had encouraged many GPs to participate dynamically in the wider NHS rather than concentrate solely on their own practices, and GPFH consortia and Total Purchasing had encouraged more collaboration between participating GPs. Thus, the ‘competition’ mechanism of purchasing had simultaneously encouraged networking between practices and with hospitals. All three PCOs tried to maintain clinical contact across organisations, though these involved fewer GPs than in GPFH. There were plans in both PCT1 and LHB1 to reintroduce some of the local focus for purchasing which had characterised fundholding. It was hoped that this would re-engage GPs in purchasing, which had become primarily an officer-led function.

As pointed out in 4.2.3, changes in GP contracts enabled PCOs to purchase additional services from GPs, and was thus a useful tactical mechanism for adjusting community-based health care to local needs.

In summary: current market mechanisms were tactically ineffective in promoting quality in hospital services, though more successful in primary care-based services. GPFH had been effective in improving the quality of a limited range of health care, and had been a genuine strategic market alternative to hierarchical governance.

4.4 GP contracts

Insofar as the 2004 GP contract (like the last, introduced in 1990) represents an increasing degree of prescription by central government of what GPs do, it may be regarded as primarily a hierarchical governance mechanism. Insofar as it allows for the local purchasing of services from those GP practices willing to expand their practices, it may, like PMS, be regarded as a market mechanism.

A key emphasis of the new contract was rewarding the quality of general practice work rather than simply the quantity. Informants saw the quality and outcomes framework (QOF) as generally useful, despite the risk that it might become just a tick-box exercise. At this point, its influence on quality was limited, but its potential would

increase as PCOs become more experienced in using the QOF as a lever for change. GPs were also generally positive about the QOF's contribution to quality.

Because the new contract and PMS allowed for local variation, PCOs had an increasing ability to match local services to local needs. However, PCOs have found it virtually impossible to withdraw from their SLAs with hospitals the money saved by substituting community-based alternatives: these latter have therefore been funded by development money.

In summary: primary care contracting is a useful tool for promoting quality, which can be classified as hierarchy at the strategic level and market at the tactical level.

4.5 Networks

Networks may be divided into inter-organisational (external) and intra-organisational (internal).

4.5.1 External networks

External networks consisted primarily of collaborative working with hospital services providers, other PCOs, and local government. The creation of provider trusts and PCOs has increased the number of stakeholders in local health economies who must cooperate to develop local services. Stakeholder networks operate both strategically and tactically.

All three sites were involved in strategic planning about the changing configuration of hospital services, which involved several PCOs and several hospitals. This was much further advanced in the case of PCT1, where the need to rebuild local hospitals had become urgent earlier. Care pathways relocating services from hospital to the community were being implemented. PCT2 and LHB1 hoped that reconfigurations would enable similar relocation, relying on strategic planning by means of consultation and consensus rather than on purchasing: network rather than market methods.

Collaboration with hospital services reflected the need to work together tactically to make local service changes and achieve national targets: no single organisation working alone could reduce waiting times, for example. Bringing clinicians from hospital and primary care settings together was an effective way of re-designing specific services and securing 'buy-in' by relevant parties, although clinical involvement was less than under GPFH: some GPs who had participated in GPFH found PCO purchasing too bureaucratic and officer-led. Collaborations with other PCOs were stimulated by the need for combined strength and/or for economies of scale when purchasing hospital services. In all three sites there was evidence of collaboration with local government: jointly commissioned services, jointly provided services, and/or joint appointments.

These inter-organisational alliances can be understood as true networks insofar as, rather than being formally organised as combined organisational structures, they are essentially voluntary relationships. This is not to deny that central government strongly encourages such relationships.

4.5.2 Internal networks

By contrast, PCOs must be regarded as very imperfect networks, in that they are compulsory and formally structured. 'Buy-in' to this collaborative approach was variable among PCO personnel. Indeed, internal networks partly served as a way of handling inter-professional differences and rivalries. For example, GPs' emphasis on financial incentives for themselves were somewhat irksome to some other PEC members in the PCTs, while some GPs felt alienated by new nurse-led developments fostered by LHB1.

There were tensions between the bureaucratic and clinical functions and personnel of PCOs. Formally, this functional division is embodied in England in the separate functions of the PCT board and the Professional Executive Committee, and documentary analysis showed broadly that this intended division of labour is observed in practice. But PECs were not regarded as very successful in either PCT, mainly because of lack of clarity about their role. It was clear that the bureaucratic activity of PCOs, unavoidable in statutory bodies with statutory functions, had alienated many GPs, including some who had taken leadership roles in the past.

Administering the new primary care contracts (with GPs, dentists, pharmacists and optometrists) required PCOs to have close links with contractors. PCOs' role as agent for the Department of Health gave them increased authority, but the reluctance of many GPs to accept PCO surveillance meant that officers tried to avoid a 'policing' style, preferring to describe their role as one of facilitation and support.

Thus, network approaches were used tactically to progress work on quality issues (service developments, clinical governance, staff development, and so on). For many GPs, PCOs were a thinly disguised form of hierarchical-bureaucratic interference with small businesses.

In summary: the internal networks that comprise PCOs are tactical rather than strategic, and are not genuinely self-organising collaborations. PCOs' external networks are voluntary and therefore self-organising, and operate both strategically and tactically, but without the power to depart from top-down directives.

4.5.3 Patient and Public Involvement

Throughout the period 1991-2005, public accountability remained weak, despite continuous government exhortations and innovations to strengthen it. All the PCOs put considerable effort into what was acknowledged as a difficult and time-consuming task that was never more than partially successful. Nevertheless, patients or members of the public did have some input (into committees or planning groups, or at board meetings), and may be regarded as members of both the internal and the external networks.

However, despite government rhetoric, there is little sense that patient and public involvement is powerful enough to set policy direction, nor that it would be allowed to do so were its policy preferences at odds with those of central government, or with evidence-based good practice.

In summary: patient and public involvement continues to be a weak component in the NHS policy network.

5. *Conclusion*

The evidence from this research suggests that there is little doubt that the dominant strategic governance mechanism in the NHS continues to be upward hierarchical accountability to national government, at any rate in the experience of those working in PCOs. Increased flexibility associated with markets and networks is not evident at strategic level, although at the tactical level, the NHS now uses a wider variety of market and network mechanisms than prior to 1991.

GPFH and its variants were effective strategically: within the limits set for the scheme, they allowed GPs and their staff much greater influence, and as a consequence genuinely allowed the ‘invisible hand of the market’ some real power in reshaping local services. Since GPFH, market mechanisms have continued to be useful tactically in primary and community health care, but have been ineffective in influencing the quality of hospital care.

Networks in and between PCOs do not reflect a genuine dispersal of accountability among multiple stakeholders, but are tactically necessary to achieve compliance with government policies and requirements, and in the strategic re-design of hospital services.

Thus, the narrative that public sector management has witnessed the eclipse of hierarchy is not borne out in any simple form in the case of the NHS. Data from this study suggest that it is certainly not true at strategic level, with the single transitory exception of GPFH. Otherwise, structural reorganisations have proved ‘on the ground’ to be less radical than they appeared, in that market and network mechanisms have not been strong enough to challenge hierarchical governance.

Activities and outputs

A number of academic papers are in preparation, on the following themes:

- board meetings as a public accountability mechanism
- role of PECs
- PCO boards: trust versus challenge

REFERENCE No.

- NHS reforms since 1991 viewed as New Public Management reforms
- what sort of networks are PCOs?
- clinical governance as an exemplar of the tensions between clinical and bureaucratic perspectives

Impacts

None as yet.

Future research priorities

The impact of the multiple market mechanisms currently being introduced in England on:

- the role of hierarchy (government)
- engagement of GPs in commissioning
- differences between the NHS in Wales and England
- patient and public involvement

Comparison of changes in governance in health and other sectors as experienced by those working within delivery organisations.

References

Bevir M (2003) A decentred theory of governance. In: Bang HP (ed.) Governance as social and political communication. Manchester: Manchester University Press.

DH (Department of Health) (2001) Shifting the balance of power. London: Department of Health.

Exworthy M, Powell M, Kohan J (1999) The NHS: quasi-market, quasi-hierarchy and quasi-network? Public money and management, 19, 4, 15-22.

Exworthy M, Wilkinson EK, McColl, Moore M, Roderick P, Smith H, Gabbay J (2003) The role of performance indicators in changing the autonomy of the general practice professions in the UK. Social Science and Medicine, 56, 1493-1504.

REFERENCE No.

Hoggett P (1996) New modes of control in the public service. *Public Administration*, 74, 9-32.

Kickert WJM, Klijn E-H, Koppenjan JFM (1997) *Managing complex networks. Strategies for the public sector*. London: Sage Publications.

Mays N, Wyke S, Malbon G, Goodwin N (eds.) (2001) *The purchasing of health care by primary care organizations. An evaluation and guide to future policy*. Buckingham: Open University Press.

Rhodes RAW (1997) *Understanding governance. Policy networks, governance, reflexivity and accountability*. Buckingham: Open University Press.

Rose N (1999) *Powers of freedom. Reframing political thought*. Cambridge: Cambridge University Press.

Secretary of State for Health (1997) *The new NHS. Modern, Dependable*. London: The Stationery Office.

Thompson G, Frances J, Levacic R, Mitchell J (eds.) (1991) *Markets, hierarchies and networks. The coordination of social life*. London: Sage Publications.