

The following six related articles, commencing with Professor Marsland's piece in MSN Volume 14, Issue 2 in April 1989, and concluding with his report in MSN Volume 19, Issue 1 in December 1993, are published here, together, for the first time.

PROGRESS IN HEALTH CARE: A SOCIOLOGICAL APPRECIATION OF THE NHS REVIEW AND ITS POTENTIAL BENEFITS

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Reactions to the NHS Review seem so far to be wearisomely predictable. The opposition parties in Parliament, their media allies, the left en bloc, the health unions from the BMA downwards, and orthodox opinion in the social sciences have condemned it in its entirety. One might be forgiven for thinking that the Review were recommending an equivalent to Dean Swift's ironically intended final solution to the Irish problem - eating babies. One might imagine to judge from the self-righteous hysteria provoked in the health establishment by the Government's modest and cautious proposals that the NHS were beyond improvement, and as unimpeachably sanctified by history and tradition as Magna Carta.

Challenges to this chorus of negativism have so far been few and far between. One interesting and important exception, however, was provided by Chris Ham of the King's Fund Institute, writing - where else - in "Marxism Today" (March, 1989). Headlined "Kenneth Clarke: far reaching and imaginative proposals", he rejects opposition allegations that the Review is a prelude to privatization, and suggests that introduction of incentives for doctors and hospitals will produce services which are more responsive to patients. "In tandem", he says, 'competition between providers will be used to stimulate greater efficiency in the use of resources'. He counsels a "discriminating response" by "those on the left", and argues that "outright rejection of the White Paper would be both wrong and a missed opportunity". While advising of possible dangers, he provides what is unambiguously a positive evaluation of the Review overall, admitting weaknesses in the NHS which have for too long been irresponsibly denied, and urging solutions to these problems along the broad lines recommended in the Review. Thus:

"The NHS clearly has a number of weaknesses that need to be tackled, including a lack of responsiveness to patients, the wasteful use of resources, and the lack of accountability of doctors. Where the Government's proposals offer the prospect of addressing these problems, they should be welcomed".

I would broadly agree with this analysis, which finds further support in a new study of consumer preferences by Peter Saunders and Colin Harris ("Popular Attitudes to State Welfare Services", Social Affairs Unit, 1989). I would seriously advise colleagues involved in research and policy analysis in the health sphere to reflect carefully on the deficiencies in existing health care arrangements and the scope provided by the Review for real improvements in the quality of service offered to the mass of ordinary people before they join the unthinking chorus of condemnation. It goes without saying that serious reform - any serious reform - always involves risks, always imposes costs, and usually leads to at least

some major mistakes which will need correcting. But without serious reform we face in health, as in every other sphere, stagnation and decay.

Reviewing the Review

There seems to be eight major topics in the reforms proposed by the Review. I shall briefly comment on each of these separately, indicating the major lines of criticism and the counter-arguments. In this I shall limit myself to practical and policy considerations.

In each case I shall add some further specifically sociological observations designed to open up technical debate among readers of this journal. In this aspect of my analysis I am drawing in part on the critique of orthodox modern British sociology which I have presented in my book "Seeds of Bankruptcy" (Claridge Press, 1988) and elsewhere.

For Medical Sociology seems to me at least as much prone as other sub-fields of the discipline to fundamental errors in theory and methodology. In the sphere of health, sociological errors and confusions have produced a contradictory mixture of hysterical critique and craven flattery of existing health care institutions. Perhaps the Review will provide the opportunity for Medical Sociology to review itself and thus to amend and strengthen its analysis.

Self-governing hospitals

The Review proposes the establishment of NHS Hospitals Trusts which will allow major hospitals to become self-governing. Criticisms are of three kinds. First the danger of self-government becoming privatised independence; secondly the risk that local provision of essential services may be threatened; and thirdly the challenge posed to supposedly essential large-scale planning. On the first, the Review and the Government are clear and firm: no privatisation is intended. Similarly the Review unambiguously guarantees that essential local services will be protected. The third criticism goes to the heart of this first proposal. The basic assumption underlying it - which I find entirely persuasive - is that bureaucratic planning has failed, and proved itself thoroughly counter-productive. Major hospitals need the freedom and flexibility which only self-government can offer if they are to serve the complex, changing needs of patients well.

The sociological issues posed by this first proposal - how to optimise effectiveness in complex organisations, how to provide coherent services while avoiding bureaucracy, how to provide for planning without impeding initiative are all standard themes in general sociology, but somehow curiously neglected in recent medical sociology.

Re-structured health authorities

The role of the health authorities will be substantially changed by the Review's proposals concerning self-government, funding, management, and family doctors. There was in any case much dissatisfaction, internal and external, with their operation even before the Review was contemplated. It seems a little curious therefore to find critics rushing to the defence of the RHAs.

The proposed changes are intended to make them more professional and more efficient, and to reduce politicisation. All of these are surely proper and sensible objectives, likely to be resisted only by those with a vested interest in political interference in health care management.

For sociologists extremely interesting and important issues are raised about the relations in a democracy between the central state, the local state, organised labour (particular professional labour), and specialised institutions and their senior managements. Querulous

one-sided complaints about centralization hardly seem a plausible approach to investigating such complex issues with the dispassionate care they call for.

Flexible funding

RAWP and its associated elaborate formulae and procedures are to be replaced by simpler methods of resource allocation and an internal market. This seems to me potentially one of the most radical proposals in the Review. Critics object mainly in terms of "thin end of the wedge" argument about markets, and out of what looks to me very simple prejudice against any serious use of monetary criteria in welfare services.

On the issues involved sociologists ought to be capable of providing useful guidance. In any large-scale organization - and the NHS in as big as any - internal resource allocation decisions are inherently problematic. The choice - which commonly turns into arbitrary oscillation between de-centralised competitive procedures and authoritarian centralised systems regularly turns out to be a "Devil and the deep blue sea" scenario. An internal market, recognising real cost, profit, and efficiency centres, perhaps offers a way through this deep-seated dilemma.

Modern management

The Review heavily emphasises the need for improved management capable of providing value for money and handling the more complex tasks posed by the other proposed reforms efficiently. The over-bureaucratized structure currently in place is to be streamlined to allow local management "to get on with the task of managing".

In the main, criticisms have focused on the supposed threats to union pay negotiating strength. Of course these anxieties must be attended to, but in principle there seems to be no reason why more localized authority, including even pay flexibility should not be advantageous to the majority of health service personnel. And in broad terms - in which for once sociologists might concur with the man and woman in the street - it is surely desirable to make a serious effort at reducing bureaucratic over-management and giving managers at all levels the discretion they need to do their essential job well?

More consultants

At least one proposal in the Review which should escape criticism is for a significant increase in the number of consultants. This should at the same time reduce waiting lists and improve career prospects for junior doctors. However, alongside this increase in resources, the Review promises a new and more effective form of medical audit, confidential and peer-controlled, but nevertheless seriously equipped with teeth.

This whole package, which also includes reform of merit awards, seems to me sensible and overdue. It acknowledges consultants' crucial importance and indispensable value, while at the same time seeking to limit any possible abuse of their considerable power.

Medical sociology has tended by and large simply to treat senior doctors as villain-chieftains of the so-called "medical model". Perhaps we may now hope to see more careful attention to the real complexities of the work and careers of specialist senior medics?

Healthcare at the front line

As I write, a large-scale "mutiny" among GPs in the face of the Review's proposals is brewing. This is predictable and understandable. At first blush the main thrust of the Review is to set cash limits and require GPs to pay more attention to their costs than has been usual.

However, it seems to me a short-sighted reaction. The Review acknowledges generously the key role of family doctors in health care which is likely to increase still further as the emphasis shifts from treatment to prevention and health promotion. Larger practices are to have their own budgets and the capacity to spend it on the patient's behalf wherever they can get the best deal in terms of quality and price. Savings can be ploughed back into improvements in the practice.

This redresses the balance between doctors and hospitals significantly. At the same time these proposals are likely to reduce drug prescribing - a change which nearly everyone concerned about health care has been pressing for.

No doubt some doctors will be anxious about their capacity to handle their new freedom and responsibility, and critics have argued that attention to budgets will distract doctors from quality care. There may be need for some adjustments to this segment of the Review's reform proposals. But this has been anticipated from the start by the - supremely pragmatic - Minister, and it seems to me equally likely that the pay-off to patients in terms of improved quality of service will be higher from this part of the reform proposals than from any other.

Hopefully sociologists will be joining actively in careful, objective evaluation of the consequences for patients.

Patients first

The whole Review is focused on improving the quality of care and service for patients. It is a health consumers' charter. More specifically the Review calls - not before time - for appointments systems, improved waiting rooms and family facilities, information about facilities and services, better complaints procedures, etcetera.

All this seems to me absolutely commendable. One of the gravest weaknesses of the NHS has been the tendency for patients' interests as consumers to be ignored. Even a state monopoly is after all a monopoly. I find it surprising and disappointing that in general sociologists have done so little by way of acknowledgement and exploration of this serious deficiency.

Towards the future

The eighth and last aspect of the Review I shall deal with concerns the private sector. Here the left were anticipating a dreadful lurch away from basic NHS principles, while the right were sullenly resigned to their demands for a serious reconsideration of 1940s thinking being ignored altogether.

As it turns out, the Review Charts a moderate path which seems to have perplexed left and right alike. Tax relief on private insurance has been offered to the over-sixties, and various suggestions for collaborative partnership between the independent sector and the NHS have been proposed.

Of tax relief the Nursing Times (Vol. 85 No 6 February 1989) says plausibly enough that it "will generate enormous ideological debate, but in short and medium terms at least its direct effects are likely to be very limited". For sociologists the Review's considered allegiance to the status quo in this ideological debate - that is to say a positive partnership between public and private, with the former substantially predominant - should provide an opportunity for more dispassionate and open-minded analysis of private sector provision than has been typical hitherto.

Even the most careful studies, such as Joan Higgins' "The Business of Health Care" (Macmillan, 1986), have tended simply to presume that the private sector's contribution to health care is unnecessary, regrettable, and overdue for termination. We might now show

ourselves at least as pragmatic and open-minded as the Review, and assess the public/private balance on its merits.

Saunders and Harris conclude their analysis of popular attitudes to state welfare services as follows:

“If this analysis is correct, then the choice for those concerned with public policy is clear. They can attempt to suppress the growing demand for the right to exit from the state System, or they can start to restructure the system of state support so as to enable consumers to express their preferences effectively. State monopoly provision in kind is being rejected by increasing numbers of people, but the state still has an important role to play as a facilitator rather than a provider. Policy-makers would best be advised to work with the change that is coming by enabling people to purchase the services they want, rather than attempt to stand out against the tide”.

This tide is not to any substantial extent reflected in the White Paper, which largely concerns itself with improving the capacity of a better organised and more effectively managed NHS to provide good quality, value for money, care for patients. Not, however, does it exclude movement in a more liberal, less monopolistic, direction in the future, supposing popular demand were to shift as Saunders and Harris predict.

Perhaps sociologists will manage - despite the persisting influence in medical sociology of such work as Navarro's, and our tendency to treat the NHS as an index of welfarist virility rather than as a practical instrument for delivering certain important services effectively to achieve at least the White Paper's level of honest pragmatism. What matters most, surely, is that our excellent doctors and nurses should have the administrative systems, management structures, and resources available to them which will allow them to give their patients the best of care.

THE NHS REVIEW: THE NEED FOR A CRITICAL SOCIOLOGICAL ANALYSIS

Gareth Williams and Jonathan Gabe

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David Marsland (*Medical Sociology News*, April 1989) is right to say that medical sociologists need to develop a critical analysis of existing health care arrangements. In most other respects, however, his advice seems to us to be woefully wide off the mark. His assessment of the substance of the Government's review of the NHS, *Working for Patients*, provides little more than an additional gloss upon a document that is glossy enough already and can perhaps be treated as just an exercise in apologetics. However, in passing, Marsland attempts to prescribe what a proper sociological analysis should do and to develop a characterization of recent developments in medical sociology. We would like to make a few comments about these matters before taking up some specific points he makes about the White Paper.

Marsland makes much of the need for dispassionate study and objective evaluation, viewing most criticism of the White Paper as little more than 'an unthinking chorus of condemnation'. Yet his own commentary is replete with value judgements about 'the Government's modest and cautious proposals', 'the supremely pragmatic Minister', 'a large-scale "mutiny" among GPs', and 'our excellent doctors and nurses' (the last two being illustrative, respectively, of just the 'hysterical critique' and 'craven flattery' for which he lambastes medical sociology!). how do such statements square with his commitment to value-freedom? Although it may be difficult for a long-time devotee of Talcott Parsons to grasp (Ramazanoglu, 1987), the value-laden language reflects the inescapable ethical and political underpinnings of any sociological and political underpinnings of any sociological analysis. Marsland should come clean and acknowledge his strong attachment to the neo-conservative ideology informing the Review.

Marsland's criticisms of medical sociology are blunted by his somewhat eccentric reading of the history of the subject. What evidence is there, in the history of medical sociology, of 'the persisting influence ... of work such as Navarro's? And on what basis can he argue that the discipline has ignored the interests of patients as consumers? It seems to us that both these claims are false. Indeed, Marsland's claim can be inverted. What is striking about the history of medical sociology in Britain, in contrast to the United States, is the absence of an avowedly Marxist perspective on health care and the popularity and influence of studies of patients' views of different aspects of the health service – the studies of Stimson and Webb, Cartwright and her colleagues, and Jefferys and Sachs are just some of those that spring immediately to mind.

In relation to the White Paper itself, Marsland develops two main points first; that the Review should not be seen as a prelude to privatization (we have Kenneth Clarke's assurances on this, after all); and secondly, that many of the proposals offer the possibility of real improvement in the quality of health care delivery to the mass of ordinary people. These points are then examined, or at least reiterated, in relation to the major initiatives proposed in the White Paper. Let us look at a few of them.

Marsland believes that under the new proposals that health authorities will become more professional and efficient and less political. This is a curious interpretation of a document which, in response to the perception that District Health Authorities are 'neither truly

representative nor management bodies' (Working for Patients, p64), proposes to eliminate elected representatives altogether! How can a system in which the Secretary of State ultimately determines the composition of health authorities at both regional and district level be seen as a reduction of 'political interference in health care management'? Moreover, it is hardly surprising that many GPs are sceptical of the Government's claims to be working for patients when the proposals specify that the number of GP appointees to Family Practitioner Committees be reduced to just one, with no obligation to include among the five lay members representatives from the local community. As for the patients, it is unlikely that Community Health Councils (CHCs) will adequately reflect the needs of 'consumers' when they are given no place on decision-making bodies and, for all his expressions of concern for the consumer, Marsland seems to have ignored the criticism that consumers' representatives themselves have produced in response to the Review (e.g Gaffin, 1989).

Looking at the opportunities presented by the proposals for hospitals to become self-governing, Marsland maintains that this is nothing to do with privatization and that local services will be protected – though he provides no arguments to support these contentions. By what mechanisms will the health care needs of local communities be assured? Surely once a hospital opts out of the control of the District Health Authority (albeit remaining within the ambit of the NHS, and begins to enter into contracts for the services it offers, the only way in which core services will be protected for the local population will be through the introduction of cumbersome regulation procedures (Paton 1989). It is unlikely that the new profitable trusts will be happy to do this and it therefore increases the probability of a move to full privatization, with any non-market obligation to the local community being abandoned altogether.

Marsland also claims that the cash limits proposed for GPs will have major benefits for patients in terms of improved quality of service, but he fails to ask, 'for which patients'? It is likely that fixed budgets for larger practices, together with the proposal to increase the proportion of practice income derived from capitation, may act as an economic disincentive to the enrolment of those categories of patient (e.g the elderly) who have the greatest health care needs. Any attempt to identify in advance high risk categories of patient and adjust the capitation fee paid accordingly is fraught with difficulty, as Flemming (1988) has demonstrated with regard to the current capitation fee structure.

These points cast doubt upon Marsland's grasp of the significance of key proposals in specific areas. But there is a more general intellectual lacuna. Marsland takes at face value concepts of efficiency, consumer preference and value for money, reflecting not at all upon either the complex meanings of the terms, or the structural realities which they purportedly describe. The fact is that the use of these terms signals a shift in the whole system to one geared to buying and selling, with cost reduction coming before the treatment of patients; and such a structural shift will act to destabilize the NHS (Robinson 1989). This will benefit the acute rather than the chronic sick, the wealthy rather than the poor and the hospital rather than the community; benefits which, on any 'objective' analysis of present and future health care requirements, is just what our society does not need. How, and for the benefit of whom, will an internal market resolve the problematical decisions of internal resource allocation? It will certainly not benefit, for example, the elderly person with arthritis (Haslock 1989).

Whatever the Secretary of State says, the reforms set in motion a process of change which will enable the NHS to be dismantled when the opportunity presents itself (Petchey 1989): a conclusion reinforced by the record of the present Government in other areas of economic and social policy. Marsland argues, with touching innocence, that serious reform always involves risks and costs. But who decides the level of risk and upon whom the risks are to be

foisted? These are questions about political power which any critical sociological appraisal of the NGS Review has to ask. Marsland would have us assess the Government's intentions for the NHS by taking their proposals item by item, on their merits. What kind of sociological analysis is that? It makes no sense to look at their proposals for the NHS out of relation to the wider strategy upon which Mrs Thatcher has been engaged – with some tactical variation – for almost a decade. This is not a form of 'hysteria', but an attempt to understand specific policies in the wider economic, political and ideological context. Such policies are part of a coherent attempt to move from a mixed to a market-orientated economy. This has involved an assault on the power of the professions such as medicine, along with a sophisticated attempt to reconstruct the ideological terrain so as to emphasise personal responsibility for health. Seeing the NHS Review in this context leads us to believe that Kenneth Clarke is involved in duplicity.

We do not castigate Marsland for holding his particular beliefs or values, but feel it is beholden on him to be more reflexive about the way in which they inform his writing. This sensitivity is a necessary component of a critical mode of sociological analysis. For our part, we have offered a perspective on the Review which draws on a different tradition within sociology – one which acknowledges the need for health policy to be examined within the wider context of economy, politics and ideology, confronts the reality of structured inequality and power relations and their consequences for health policy, and is wedded to the notion that health care provision should be equitable.

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REFORM OF REACTION IN HEALTH CARE?

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Parliament and the people are debating the Government's proposed reforms of health care, so why shouldn't medical sociologists join in? I was delighted, therefore, to read the response to my own analysis (Medical Sociology News, April) by Gareth Williams and Jonathan Gabe in the August issue. Before the reforms are enacted and the practical tasks of implementation are entered on constructively by all concerned, I have one last opportunity, for which I am grateful, to continue the debate.

My critics raised many interesting and important questions which will require more space for adequate response than I have here. I focus, therefore – leaving other more particular issues to be addressed in other arenas – on the two fundamental criticisms they deployed. These concern, first my alleged naivety about the concepts of “efficiency, consumer preference and value for money”, and second, the methodological role of values in social analysis.

Service for whom?

It seems to me wonderfully ironic that I should be accused of “taking concepts at face value” by critics who – in defending the status quo of an unreformed National Health Service – demonstrate their own willingness to take the thoroughly elastic concept of “service” entirely at face value. After forty years of social and medical change, the necessity of reform in British health care is now widely acknowledged. Admission that the hopeful promises of those who legislated the NHS have been less than wholly fulfilled implies no reneging on principled commitment to high quality health care for all. All that is entailed by acknowledgement of the necessity for reform is an honest, open-minded attempt at improving service quality, at turning the failed ideal of service into a reality.

In this attempt, the concepts of efficiency, value for money and consumer preferences are indispensable instruments of analysis. Despite Williams' and Gabe's strictures, each of these three concepts is clear, operational and practical. They provide bench-marks which can be applied coherently to any and all of the multifarious policies, programmes and procedures which comprise the health care system. If we measure the NHS, rigorously and across the board, in terms of efficiency, value for money and consumer satisfaction, we shall be on our way towards ensuring delivery of quality health care and genuine service throughout Britain.

Hidden agendas

While I am grateful to be spared “castigation” (Williams and Gabe, page 10) for my values – which are not dissimilar, as it happens, from those of rather large numbers of my fellow citizens – I was surprised that my critics should suggest that I need to be more open and explicit about them. I would have thought my scepticism about socialist and other collectivist principles and my resistance to sociological bias against markets, business, freedom and individualism had been set out thoroughly and explicitly in all my recent published work (please see references for examples).

My reading of British medical sociology (including Medical Sociology News) and the sociology of health more broadly suggests that the boot is on the other foot. If only medical sociologists had admitted explicitly in their relation to their analyses of the NHS, the medical

profession, health inequalities and all the rest, the extent of their own commitments to socialism, collective provision, centralised planning and union power! If only student readers of our text books had been made aware of the role of authorially hidden agendas in the elegant marshalling of arguments, and of unexplicated values in the judicious selection of evidence!

What is essential, surely, is that sociological analysis of current health care reforms should be explicit, and reflexive, about a range of values – with objectivity, validity and practical relevance being pursued through wide-ranging debate and competitive testing of a variety of perspectives. The range of value-perspectives brought to bear in medical sociology in recent years, and in analysis of the current NHS reforms specifically, seems to me to have been clearly too narrow. Those who support NHS reform have no need to apologise for attempting to widen it just a little.

Protesting too much

It seems to me that over the intervening months, Chris Ham's recommendation to "those on the left" (which I referred to in my earlier paper) of a "discriminating response" and his advice that "Outright rejection of the White Paper would be both wrong and a missed opportunity" have been sadly ignored. There is widespread conviction that the millions of pounds spent by the BMA on doctrinaire resistance to reform of the NHS have been mis-spent and counter-productive.

Reform of the NHS is essential. Our elected Government has brought forward its reform proposals for consideration in all the relevant arenas and made significant adjustments and concessions, given Parliamentary approval, the whole reform package will be implemented. If resistance persists, it will be justifiably interpreted as a product of dogmatic opposition to the whole idea of innovation and reform in health care. In a word – reaction.

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RESEARCH INTO HEALTH CARE

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Reactions to the White Paper "Working for Patients" and to the Government's Bill now going through Parliament have demonstrated that there are very few academics, journalists or social policy researchers who are not substantially prejudiced in favour of the status quo in health care.

Apart from the Health Reform Group, the Institute of Economic Affairs and the Adam Smith Institute, Kenneth Clarke has been able to rely on precious little support in his brave efforts from intellectuals in Britain. Even these exceptional cases are outside public higher education, where the bulk of research funding is spent on health care. Indeed, even from the sadly few universities where there are important centres of innovative thinking in relation to health care, there seems to have been very little by way of public support for NHS reform since the Bill was published.

ESRC-funded research projects in the sphere of health care seemed likely, to judge by recent conference papers, to produce yet more critical material, rather than anything which could provide positive assistance in the implementation of NHS reform. Social scientists generally remain thoroughly sceptical about – not to say prejudiced against – any serious role for markets (external or internal) in the health sphere; about objective scrutiny of current health care costs; about strengthening the hand of devolved management; about genuine attention to consumer perceptions and dissatisfactions; or about allowing the proper emphasis on efficiency, which along with care, is essential in a modernized, dynamic NHS.

Even the sociology and social policy now routinely taught to doctors and nurses in training is largely, if we may judge from the textbooks typically used, impregnated with prejudices incompatible with genuine reform of health care.

Lack of support for health care reform from the academic community cannot simply be dismissed as a trivial, predictable nuisance. The agenda of debate in the media and the atmosphere of public discussion are shaped to a powerful degree by "merely" academic and intellectual influences. Unless something is done to encourage a more balanced and more objective approach in research and analysis, it seems unlikely that serious reform of health care in Britain will be successfully accomplished.

In private sector research, it would generally be considered foolish to commission studies from sources who were known to be opposed in principle to the service or commodity being researched. It would not be regarded as in any way prejudicial to place research with investigators who were believed likely to approach their task open-mindedly and in a spirit of honest practicality. Why should it be any different in the public sector?

It seems to me there are two distinct constituencies with a real interest in attempting to amend and improve the condition of research into health care:-

1. All those seriously concerned about current levels of costs and efficiency in the NHS, and anxious – for the sake of patients, staff and taxpayers – to see improvements.

2. All those with a broader interest in welfare reform as one fundamental aspect of the modernization of Britain. If reform is blocked or stalled in health care, moves in other spheres against bureaucracy, collectivism and inefficiency will be considerably weakened.

There are several important tasks which people who identify with either or both of these constituencies might usefully take on:-

- Monitor academic publications, especially those used in teaching health care personnel and those which are taken up by the media, for the extent of their open-mindedness and objectivity in relation to NHS reform.
- Systematically monitor the conclusions and public statements arising from research on health care funded from the public purse and publish the results.
- Identify researchers in higher education who are other than prejudiced against health care reform.
- Seek ways of strengthening funding for research undertaken by such people. Both public and private sources of funding will need to be tapped.
- Develop networks of contact between, on the one hand, academics of good reputation who are sympathetic to reform, and the media on the other.
- Establish a programme of invitation seminars over the next two years designed to examine the practical task of implementing health care reform. Key media people to be included as observers. Press releases to be attractive and professional

Since 1945, and more particularly since the expansion of the social sciences during the nineteen sixties, there seems to have been a tendency for the research community to be more than somewhat partial in its ideological inclinations. Even among economists, but especially among social historians, sociologists and social policy analysts, the tendency has been:-

- To underplay and even denigrate the potential positive role of markets, competition, enterprise and incentives.
- To over-estimate the scope for effective central planning.
- To lay greater emphasis on generalized principles of presumed social justice than on the particularities of individual consumers' wants and satisfaction.
- To underestimate costs and to downplay their significance in policy development.
- To sympathize with the concerns of trades unions and professional associations at the cost of ignoring the requirements of efficient management.
- To presume on some general trend of history towards increased state control and away from active participation by private, independent and voluntary producers and suppliers of commodities and services.

These tendencies have been apparent in most fields of social policy research, including housing, pensions, education, training, employment advice and placement, and not least health.

It seems to me unlikely that an intellectual context shaped by these tendencies can provide effective support for the radical reforms needed as much in the health sphere as in other sectors of social policy. Those who are seriously committed to reform ought, therefore, to be

giving attention to measures designed to amend the one-sided inclinations of social research. This Working Paper is designed as a stimulus and encouragement to such efforts.

RESEARCH INTO HEALTH CARE – PARTISANSHIP OR SCIENTIFIC INQUIRY

A Reply to David Marsland

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Professor Marsland's contribution to the last issue of *Medical Sociology News* (August 1990, pp. 12-15) raises a number of serious matters. Some of his criticisms should be well-taken by medical sociologists. Others, however, reveal a considerable ignorance of the literature produced over the last twenty-five years, while a few reveal an aspiration to intellectual autocracy which seems inconsistent with Professor Marsland's own philosophical roots.

Where does Professor Marsland have a point? There is some justice in his charge that sociologists have been unduly neglectful of efficiency questions, although this may not necessarily be the highest priority in a health care system that spends a proportion of GNP comparable to other Western countries (looking at purchasing power parties), but which incurs much lower administrative costs. Although there may be specific distributional problems, the NHS has, by international standards, been a relatively efficient provider of health care. However, as current thinking in the management schools reminds us, direct money costs are not everything. We also need to be concerned with effectiveness, with staff morale and with consumer satisfaction. The optimal solution to the problems of delivering any personal service will be found only by a complex balancing act between costs, quality, user-friendliness and employee welfare. There is little virtue in delivering a cheap service which is ineffective, hostile to consumers and indifferent to staff. It may well be worth paying a premium over the cheapest solution to construct an organization which provides a quality service, attracts customers, satisfies employees and has some prospect of long term survival. The 'fourth generation' evaluation studies which are now being conducted in the US have recognised the subtlety of the judgements involved in the inappropriateness of the kind of preoccupation with cost reflected in Professor Marsland's contribution.¹ When it comes to issues of quality, consumer satisfaction and staff morale, one is dealing with areas where sociologists have long made a distinctive contribution.

Professor Marsland is on stronger ground with his suggestion that medical sociologists have romanticized the role of trades unions in health care, although not, surely, to the extent of David Green's lyrical account of their role before 1911.² It seems bizarre, however, to accuse sociologists of an excessive sympathy for professional associations. If there has been a dominant obsession in medical sociology for the last twenty-five years, it has surely been 'doctor-bashing', even where this has involved a Procrustean treatment of the empirical evidence. The BMA, the GMC and the Royal Colleges have been repeatedly depicted as villains, whose power needs to be broken in precisely the sort of consumer interest advocated by Professor Marsland. What is more noteworthy is the absence of any serious attempt to understand their problems and internal dynamics in the way that, for example, Halliday has done for the Chicago Bar Association.³ Likewise, far from neglecting consumerism, this must be seen as one of the major influences on the field, despite Margaret Stacey's powerful caution against its limitations as a model.⁴ In avoiding the

language of the market, Sixties libertarianism may differ in its justifications from Thatcherism but its practical effects may sometimes be little different. Besides, Professor Marsland's consumerist solutions raise their own empirical difficulties: why has it been so difficult for American women to influence obstetric care when they were theoretically its direct purchasers, at least until the spread of HMOs? Might this not suggest that there are real problems with simple application of consumer sovereignty? Can markets always regulate supplier-induced demand?

The point is, as health economists generally recognize, that health care is not a good case for market solutions. Even Adam Smith acknowledged this in exempting physicians from his general critique of occupational monopolies.⁵ The unavoidable informational asymmetry between doctor and patient, coupled with the highly consequential nature of the decisions being made, create serious problems in equalizing the position of buyers and sellers in the way assumed by neo-classical economics. When this is coupled with the difficulties of creating a satisfactory system of insurance because of the problems of the increasing certainty of risk of uptake of the service as a result of the ageing process, of adverse selection and of moral hazard, the market provision of health care involves such torturing of logic as to appear unworthy of much expenditure of intellectual energy.

This becomes evident when one looks at the present Government's proposals. Professor Marsland criticises the reluctance of scholars to come on board and it is remarkable how isolated the Department of Health's position has become even among health economists who might have been expected to be the greatest enthusiasts for the internal market. Indeed, its alleged inspirer, Alain Enthoven, has professed himself unhappy with many aspects of the proposals and called for limited and carefully evaluated pilots to establish that there will indeed be a change for the better.⁶ The problems of these proposals, however, have nothing to do with the ill-will of scholars and everything to do with their sheer intellectual incoherence. Even for those of us who share the view that financial and management information in the NHS is inadequate, there are still plausible reasons to see the reforms as an expensive charade which depends upon a massive centralisation of power in the Department of Health and an extension of costly and unproductive regulation, financed by a transfer of resources from patient care to administration, which will aggravate rather than relieve the funding problems of the service. In the circumstances, the reaction of many in the academic community may be more comparable to the reluctance of seamen to enlist on a leaky tub than any fundamental ideological animus.

Professor Marsland's response, however, lacks the seriousness he finds wanting in others. If the community of scholars will not come on board, he will reintroduce the press gang. This response has already disconcerted a number of other libertarians like Professor Kedourie, who recognize that the logic of their own position calls for the sustenance of free thought and inquiry and that these are threatened by the demand for political commitment as the price of public support. As Hayek rightly observed, we cannot foresee the future in detail and part of the policy of any state must be the deliberate fostering of a diversity of perspectives offering politicians and public a variety of options for conduct under whatever environmental conditions prevail. If the market fails to provide this choice, because of its emphasis on the here-and-now rather than on the medium and long term, then this failure may legitimately provoke Government action.⁷ Some part of this is undeniably the latter-day equivalent of the servant retained by the Roman Senate to whisper in the ears of triumphal Caesars that they too are mortal. Professor Marsland may choose to disregard the message but in shooting the messenger he is trampling on the very democracy he claims to represent.

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IMPLEMENTING HEALTH CARE REFORM: FROM POLICY TO PRACTICE

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A paper presented to the Panel on Progress in Health Care Reform at the 25th Annual Conference of the BSA Medical Sociology Group, York University, September 1993.

The other members of the Panel were Dr David Armstrong (Department of General Practice, UMDS Guy's Hospital); Professor Robert Dingwall (School of Social Studies, University of Nottingham); and Dr Jennie Popay (PHRRC, Salford). The Chairman was Dr Nicholas Mays (Director, Health & Health Care Research Unit, Queen's University of Belfast).

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In the three decades between the establishment of the NHS and 1979, expenditure on health care expanded dramatically and the size of its staff grew explosively, while the number of patients treated and the amount of actual health care work accomplished stood more or less still (Gammon, 1987).

This is a typical picture of any nationalised industry: squandered investment, a manpower budget out of control and poor productivity. All this is despite the exceptional calibre of our medical research, the international reputation of our doctors and the traditions, discipline, commitment and high quality of British nursing.

The founding intelligentsia of the NHS proclaimed and promised – implausibly enough, one might have thought, even in the innocently idealistic climate of the nineteen forties – that, after high initial costs, future expenditure on health care would be reduced in absolute terms, as people were brought into a healthy condition by the new system. As it has turned out, costs and expenditure have consistently escalated to a level which both major political parties and most sensible people agree must be controlled.

Widespread dissatisfaction with the NHS

On top of all these objective problems with the NHS, there was also by the nineteen eighties considerable dissatisfaction with its performance:-

- On the part of professional staff objecting to irrational resource constraints and bureaucratic interference in their day-to-day work by the health authorities;
- On the part of innovators and radicals who found it resistant to new ideas and new challenges and fixated on outmoded objectives, methods and procedures;
- On the part of Governments, of whichever party, for whom the NHS seemed to comprise a reliable source of unexpected and embarrassing difficulties;
- And not least, on the part of the general population, on account of its negligent paternalism, its impersonal lack of attention to patients as people and their growing feeling that standards of health care were not rising in parallel with improvement in other aspects of the standard of living and the quality of life in modern Britain.

By the mid-eighties, it was evident that, despite continuing ritual acclaim of the NHS as a potent symbol of politically correct aspirations, the objective quality of health care in Britain had been overtaken in many other countries. It was widely acknowledged that radical reform was essential (Scrivens, 1991 and 1993).

Reporting progress

Since the reforms were inaugurated, their progress has been reported by the media and by most social scientists of health as if by the peace party in a period of war – with every next military disaster gleefully exaggerated and imminent surrender enthusiastically anticipated. Weaknesses and failure going back years, some of them apparent since the inception of the NHS, are routinely mis-attributed, with cavalier inattention to the evidence, to the reforms and to the Government.

My view is different. So far, so good. We must press on in the face of predictable resistance. I enter two caveats:-

- First, it is still too early to make definitive judgement about the overall success or failure of the reforms. Critics and proponents alike are eager to find confirmation of their prejudices. But these are wide-ranging, radical reforms of a massive, complex, entrenched system. It will take at least as long to establish fully and reliably their negative and their beneficial impacts as with comprehensive schooling, nationalisation, the nineteen sixties transformation of the criminal justice system or the nineteen eighties reform of trades unions.
- Secondly, as these examples suggest, the interface between objective evaluative judgement and ideological commitment – where matters are properly adjudicated by the people at elections rather than by the advancing knowledge of experts – is treacherously difficult terrain.

It seems to me that the relevant criteria for evaluating Government reforms, at least in a liberal democracy, are the Government's own objectives – not the Opposition's, still less the utopian dreams or irrational worries of agents and agencies privileged to avoid reality-testing entirely.

In these terms, my assessment is of mixed but fair success so far. I will mention the successes as I see them on the basis of the evidence so far in and some remaining difficulties.

The Trusts

The Trusts have grown at a rate which their enemies claimed was impossible – almost 300 already, and a further large tranche anticipated in 1994, bringing coverage to more than 90%. They have become already normalised. The intended effects of their new status, of their autonomy, and of their enforced self-reliance in a competitive environment are coming through rapidly (Times, 21 August, 1992).

They are shaping up organisationally, sorting out their budgets and their manpower, addressing purchasers confidently and orienting to patients as people and as consumers. Most are improving their standard all round. Some may need new leadership. A few will go the wall. Overall, the Trusts are proving a triumphant success.

The morale problem – which is hardly new in the hospitals – will take time to solve. The trades unions and the professional associations, whose reactions to change powerfully influence staff morale, may need yet another Conservative electoral victory before they yield. The BMA stood out longer and more toughly, we should remember, against contraception

and indeed against the NHS as such. The Trusts will not in the end be sabotaged and the productive impact of competitive autonomy will continue.

GP fund-holders

Here, the movement has been slower and resistance more organised. But the trend is set and the numbers will expand until this second key element of the reforms is as normalised as the Trusts. Already more than 6,000 GPs are involved, covering one in four of the population. A fourth wave from April 1994 will increase this substantially.

The beneficial impact of GP fund-holding is even more evident than with the Trusts – as the clamorous complaints about a two-tier system demonstrate (survey in *Doctor* magazine, 7 October, 1993). Enforced equalisation of standard guarantees levelling down and the lowest common denominator. Competitive autonomy is creating a dynamic multi-tiered system, with standards of care, expertise, management, facilities and attention to patients as people improving across the board, and inadequates squeezed out.

Purchasing

Purchasing, other than by doctors, is still inchoate and inadequate. I would not expect otherwise at this stage. Purchasing in general is a more difficult art within the market enterprise than selling. The forms of organisation and the personnel involved in the Authorities were designed for a command economy of health care, rather than for the subtleties of an internal market.

More structural changes, more learning and more changes in personnel will be needed. Dr Mawhinney's recent speeches on purchasing are having a powerful effect. "Purchasing", he has said, "is the engine which drives the reforms". "From first to last", Mrs Bottomley argued at a recent NAHAT conference, "it is purchasers who should be in control. They pay the piper. They must call the tune".

If this ambitious claim is to be fulfilled, the activities of the health authorities as agencies of state purchasing may require some independent competitive stimulus. Why not introduce incentives for big companies, which have the experience, skills and systems required for effective purchasing, to purchase health care for their employees and their families through the workplace?

Funding and the market

Until the purchasing component of the market equation is brought up to the strength of the new provider element, it is difficult to judge the dynamics of the whole system fairly. I would expect Government to relax central and regional controls gradually, to restrict its interventions to serious crises and to release the internal market to operate much more freely.

This will no doubt provoke problems and protests from time to time – the London situation being a peculiarly awkward and difficult example. But the process will continue to go forward, until even a Labour Government would not be able, or in the end willing, to reverse the process and return to centralised planning. Nostalgic pleas by academics and by health correspondents in the media for "tighter management" – i.e. subversion and sabotage – of the market should be ignored (Conservative Research Department, 1993).

Public expectations

The reforms have already had a dramatic effect on public expectations in relation to health care. Among politicians, in the media and among the people, expectations have risen, and

deferential tolerance of inadequacies has fallen away. This was intended; the Charter is designed to strengthen it and is unarguably a positive gain (Department of Health, 1991).

But it has to be steered responsibly if we are to avoid what one might call “post-communist syndrome”, where unrealistic demands, combined with unwillingness to take on individual responsibility, produce a neurotic reaction into antique authoritarianism. Thus, independent health care should grow gradually and in positive collaboration with the NHS as the effects of the reforms on expectations and demand unfold. Journalists and social scientists should draw attention just occasionally to the responsibilities of individuals for their own and their families’ health care in terms of life-style decisions and spending priorities.

Sources of concern

In concluding, I will mention two concerns of mine.

The concept underlying “The Health of the Nation” seems to me valuable and timely (HMSO, 1992). It portends a long overdue shift from treatment to prevention and health promotion and from the hospital to the community as the centre of gravity in health care. However, the implementation of its message worries me.

It might provide the ground on which forces antagonistic to health care reform can re-group and work for the restoration of levelling paternalism. Rather than risk a growing army of missionary zealots to the general population, primed with generalised health promotion formulae dreamed up in Alma Ata of all places, I would prefer a less ambitious, more sharply targeted, more local, more practical approach aimed at clearing up the concrete health problems of the genuinely disadvantaged (Le Fanu, 1993).

My second worry is on information. The reforms require a massive upgrading in the quantity, quality and transparency of information of all sorts. Reliable financial epidemiological and evaluative information will be needed for operational management purposes, to steer the internal market and to apprise the public of variations in offerings and standards. Improvements are being made, but there is a long way to go (Marsland 1993)

CONCLUSION

Radical reform is inherently difficult, which is why it is usually avoided (Marsland, 1992). The reforms of health care seem to me courageous and broadly correct. In a remarkably short period, their implementation has gone forward strongly. I think this will continue, despite resistance and problems, until the overall thrust of reform is positively accepted by everyone except incorrigible recidivists in the collectivist lobby. Within ten years, efficiency and equity alike in the provision of health care can be substantially improved.

In his introduction, the Chairman was kind enough to say how pleased he was to welcome “a varied and distinguished Panel”. I suspect I was invited to represent the variation rather than the distinction. As a dissident among social scientists involved in research into health and health care in supporting the Government’s NHS reforms, I urge the research community to practice the open-minded, dispassionate stance which we preach to our students. The reform programme is working.

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