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Organisational Developments in Contemporary Primary Care

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Statement in support of a submission for the award of Doctor of Philosophy by published works

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November 2000

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Acknowledgements

Given both the range and involvement which have characterised the research described in this Statement it is clear that I owe a great deal to a large number: the participants in the primary care organisations studied; research colleagues; students on whom I have inflicted often partially formed ideas, and a family which has had to endure the emotional vicissitudes that seem to come with the territory.

Over the past four years I have been pleased to be a member of the Health Management Group at City University. I hope the progress of my research career reflects the real opportunities the Group has afforded me during this period. In particular I would like to thank by name Angela Coyle and Moira Dustin, without whose advice and administration, respectively, I would not have traveled so far.

Abstract

Organisational developments in contemporary primary care are the principal subject of the ten studies selected to support this PhD application on the basis of published works. The local practice and central policy determinants of these developments are discussed as a critical interaction, which is now having a profound impact on both the concepts and functions of primary care and the shape of the NHS itself.

The studies are classified and described individually in three sections, according to the main methodological approach used in each research project. The approaches were: participant observation, action research and case studies. Concluding comments suggest that the focus on relationships represents the distinctive contribution of the works covered by the Statement.

Introduction

This paper is offered as a reasoned argument in support of a submission for the award of Doctor of Philosophy by published works, to be examined in accordance with the University Degree's Ordinance 6(b). The argument is that the published papers constitute evidence of both the systematic study of and an original contribution to the subject of organisational developments in contemporary primary care, sufficient to comply with the criteria for the award of the degree of Doctor of Philosophy, in accordance with Ordnance 8(a).

The published papers contained in the submission are listed in their order of appearance in this Statement at Appendix A. They are indicated in the text by numbers in square brackets. The papers submitted comprise, exclusively, books, chapters and articles published since the writer's appointment to the City University in July 1996. In some cases, however, these draw upon research undertaken prior to this date.

A full list of published works by the author since 1990, excluding editorials, is presented at Appendix B. Further sources referred to in this statement are listed at Appendix C, and Appendix D contains details of those jointly authored publications presented as part of this submission, with signed disclaimers from the other contributors confirming the author's work.

The common subject area serving as the criteria for the selection of the published papers listed at Appendix A is the organisation of primary care, specifically across the United Kingdom, during the 1990-2000 period. This decade has witnessed an unprecedented level of national policy attention and activity in respect of primary care and a similarly unparalleled increase in local developments. In addressing specifically the organisational consequences of these changes the submitted papers have sought to explore and examine their significance at a series of intra- and inter-organisational stages, extending from the personal to the societal level. In particular, they identify the new boundaries of primary care through the organisational developments which have emerged as a result of its enhanced status in both local practice and central policy. The need to both revise past organisational theories, and create new conceptual models of organisational relationships is indicated. The work as a whole, covered by this Statement, suggests that this need should be addressed, specifically, in the interests of maintaining viable public sector health and healthcare systems in the UK.

Most of the submitted papers have groundbreaking characteristics. This applies, for example, to the case review of local primary care-led purchasing initiatives [3]; the model of network based strategies for Family Health Services development [7]; and the relational analysis of the *New NHS* [2] and [5]. In each case evidence of organisational trends developing on a pan-UK health system basis was published for the first time. As such these works inevitably offer evaluative analyses for both policy and practice which are both preliminary and partial. Their essential value, and purpose, however, has been to ensure an effective association between research *and* development at a time when the NHS has regarded the integration of these two concepts in practice as more vital than ever before, given the transformational scale and pace of its recent history.

Efficient dissemination has been a core element in achieving these purposes, representing the main bridge between research and development. Accordingly, the published works selected for this submission have been the basis for an external services programme that has included over 250 short course, workshop and conference presentations during the 1996-2000 period. These have been sponsored by a range of public and independent sector agencies, including NHS organisations, universities, professional associations, local government and pharmaceutical companies. This programme has generated over £300,000 income for the Health Management Group of City University, and a continuous supply of management models and developmental aids for the health and social care sectors.

Context

The 1990-2000 period began with new national contracts for General Medical (and Dental) Practitioners and ends with the advent of NHS Primary Care Trusts. This apparent linear progression, in policy terms, is described in Figure 1 below illustrating how, within ten years, organisational responsibilities in UK primary care have moved from an exclusive focus on the individual to those of local communities, with specific health care target groups and then the practice population serving as staging posts along the way. And as this basis for relationships has altered so too, of course, has the unit of primary care itself. It has progressed in scale from the individual Family Health Services professional contractor to the General Practice, and then to the multi-disciplinary, multi-practice grouping of a primary care agency which now fully incorporates Community Health Services personnel. The 1997 NHS (Primary Care) Act, for the first time, formally defined the latter as part of primary care and paved the way for potential future franchise arrangements. In these, the local primary care organisation may directly control around eighty per cent of NHS resources for its area, and combine both the functions of health care provision with those of commissioning for overall health improvements. In policy terms 1990-2000 represents a decade when reform has become revolution. Organisational development, understood as the way in which organisations adapt as systems to both internal and external change, has been a rich subject of study.

In practice, of course, the progression described in Figure 1 has been anything but linear. Within every health district and across many districts, the traditional model of the small primary care unit, led almost exclusively by the individual General Medical Practitioner, still pervades. Nation-wide, there has been an ever growing diversity of organizational models in primary care at practice and inter-practice level; many stimulated by the 1991-1998 fundholding experiment, and the alternative and rival schemes it spawned. The result is that policy and organisational developments are now seeking to respond to, and incorporate, three distinct strands of primary care development.

The first is that of GP-based Primary Medical Care: clinically oriented, personalized and generalist health care expressed through the registered list and the traditional surgery

CONTEMPORARY PRIMARY CARE DEVELOPMENT

Organisational Unit	Individual Family Health Services Professionals (eg GPs)	General Practice Units	Primary Health Services (ie GMS and CHS)	Primary Care Organisations
Mechanism for Delivery	Via standard national contracts	Via business plans and corporate contracts	Via practice contracts and accreditation	Via frameworks for long-term franchises and convenants
Service Focus	Individual Patients	Specified Target Groups (eg over 75s and under 5s)	Practice Populations	Local Communities

1990 → *1994* → *1997* → *2000*

GP : General Practitioner
GMS : General Medical Services
CHS : Community Health Services

Figure 1

[10, p23]

consulting room. This is the most readily recognised form of primary care, often still expressed in the popular notion that 'General Medical Practice *is* Primary Care'.

The second is that defined globally by the World Health Organisation, and others (eg Macdonald, 1992 pp 58-62) as Primary Health Care: preventative, inter-sectoral and multi-professional collaboration for population health improvements, increasingly driven by European and national-level policies for targeted public health gains.

The third strand, newly explicit and now the most powerful, is that of Primary Managed Care: the fusion of modern general management responsibilities with the GP professional, in whom the public has had the highest levels of demonstrable confidence; to exercise overall control of local NHS and associated resources, including decisions regarding relative clinical priorities and differential financial allocations. This term was first coined by the pioneer family doctor-cum-businessman, Barry Robinson, in 'Future Options for General Practice' (Meads 1996), and projected into its future operational detail by Wessex-based research on the changing responsibilities of primary care Practice Managers (Huntington, 1995).

The interplay of these three dimensions of primary care is now shaping not simply the UK health system but the wider society of which it is a part. This is why contemporary primary care developments possess a significance well beyond their intrinsic value. The General Practitioner in the United Kingdom has occupied a unique position in direct contract with both the government and the individual: a vehicle for personal concern and social care as well as political control. The privacy, respect and concern '*he*' has epitomized as a professional ideal has also represented the State's relationship with its citizens. How will this be affected by the expansion of responsibilities in primary care and the different developments these require?

Contemporary primary care, accordingly, is just as important as a determinant as it is as an agent and recipient for both health and public policy.

Approach

As a full time member of the University, appointed on the basis of a continuing financial contribution from and staff commitment to the Department of Health, the writer has enjoyed particularly favourable conditions for applied health services research, during the 1996-2000 period. In particular, this position has offered considerable scope, through a range of programmes, to explore and examine the relationship between expressed policy and espoused practice: the tensions, the differences, the areas of convergence and divergence, extending to integration on the one hand and conflict on the other. This focus has led inexorably to an overall approach in which alternative research designs for analysing, as appropriate, the formal and informal dimensions of organisational development in contemporary primary care have been identified.

These can be classified as belonging to three types of social research, the headings for which comprise the titles of the sections that follow as the main substantive Sections in this statement. They are Participant Observation, Action Research and Case Studies. Whilst individual texts are addressed within each of these sections to illustrate and justify the contribution each methodology has made, it is important to recognise that together they comprise a single, integrated approach based on the use of the *Self* as a source of translating experience into evidence. Indeed, even from the limited summaries below, it will be apparent that in terms of both research findings and perspectives there is considerable overlap and some duplication between the different designs. Collectively, however, over the 1996-2000 period, the writer would argue that they can properly be regarded as an original and coherent acquisition and accumulation of knowledge about organisational developments in primary care. Together, they represent a creative approach which has permitted both the eclectic and selective use of management and associated theories required for a real understanding of this contemporary subject area.

A. Participant Observation

The writer has undertaken a series of participant observation studies since it was the principal method employed in his first postgraduate research programme, more than 20 years ago (1975). It has, for example, underpinned a number of the writer's articles in popular health and social care journals reflecting upon the experience gained in international consultancy roles (Appendix B: e.g. Meads (2000) Primary Care in China; Meads (1993) Mission to Moldova; Meads (1993) Nuts and Baltics). In the published papers selected for this submission it was first applied in the production of *Power and Influence in the NHS: Oceans without Continents*[1]

This book seeks to understand the contemporary NHS as a political environment through its organisational behaviour. It identifies the rapid changes in primary care, as being of particular significance, in terms of strengthening the power and influence exerted informally across the health care system and its development processes. As a result real change has often emanated from those able to operate effectively through networks, alliances and coalitions – particularly from primary care bases – and who eschew the conventional authority associated with formal representative roles and positional authority. The new differences in primary care organisations arising from these changes, and their consequences, lead on to fundamental questions regarding what remains truly 'National" in the NHS. The changes are located in a grand historic context drawing upon parallels with such periods as The Dark Ages and The Renaissance. These same fundamental questions are those that the new Government in 1997 sought to address through, for example, re-emphasising NHS core values and common standards . The analysis offered in *Power and Influence* is derived from the writer's participation - in senior management roles - in the actual events addressed. It is legitimised by the 'process of self objectification' (Vidich, 1954), which is an essential part of the field observer's role, leading to a description of variables and the formulation of insights otherwise precluded by laboratory hypothesis testing or experimental research studies of a particular community (Scott, 1965 pp 267-271). As components of the conventional scientific research methodology, the latter are designed for and suited to steady state systems, but are inadequate as vehicles for understanding the scale and pace of change in the contemporary NHS.

This new research focus is on organisational behaviour, through what are referred to as its 'relational and political processes'. In the subsequent article, *Integrated Primary Care: The Relational Challenge* [2] this perspective is presented as a conscious alternative to those policy analysts who have sought to understand the NHS through its formal organisational structures, accountabilities and systems of authority. This approach is identified by the writer as having its origins in Weber's bureaucratic model (Pugh et al, 1971), with contemporary successors in such NHS policy commentators as Ham (1992) and Harrison (1988). The approach is examined for its shortcomings in relation to sustaining inappropriate methods of rational strategic planning and scientific research investigation in the cases of, for example, defining the future role of health authorities and the evaluation arrangements for the 1997 NHS Act (Primary Care) Personal Medical Services Pilots and local commissioning groups.

It has been important to demonstrate the potential benefits of this critical appraisal of the orthodox approach to organisational development of the NHS. Making sense of the latter's organisational behaviour requires tangible outcomes and the articles entitled *Future Options for General Practice*[3] and *Getting it Together: Combining Health and Social Services* [4] both offer a series of analytical frameworks to assist with the management process. In the first instance a hierarchy of ten stages of organisational development in primary care is set out (see Figure 4 below), graduated to reflect the escalation from individual to corporate responsibilities required, as service delivery and management functions are both increasingly combined and consolidated at inter-practice and multi-practice levels. In the second *Getting it Together* case study a fivefold framework is provided as a unified set of criteria for use, in what is described as a now unavoidable convergence of community care responsibilities within primary care settings.

Such frameworks are the proper products of a participant observation approach to the contemporary NHS. As tools for both management action and policy assessment they both constitute a synthesis of personal and professional experience with detailed reflection, informed by relevant theory and research. *Future Options for General Practice*, accordingly, builds on both the writer's experience as a NHS Regional Director of Primary Care and the literature which has established the distinct concepts of primary medical, primary health and, most significantly, primary managed care (Macdonald, 1992; Starfield, 1998; Peckham et al, 1996; Fry et al, 1995). Similarly, *Getting it Together* draws explicitly on the writer's ten years field experience as a social care practitioner, with local case examples used to highlight both

the obstacles and the risks involved in combining health and social services; and it does this within the basic framework for collective and individual responsibilities that academics undertaking health services research (e.g. Klein, 1988, 1995) employ as the starting point for tracking policy trends and their consequent shifts in practice.

It is this combination which is both peculiar to participant observation and to the writer's contribution, representing systematic and original study in accordance with the terms required for this submission. The four published papers offered in this section are neither simply a manager's personal records on the one hand nor a student's selective trawl of the literature on the other. There are, of course, plenty of examples of both. What are much less in evidence, and far more valuable, however, in terms of the insights offered, is the research of a rapidly changing organisational process which both defines the significance of the subjective response and draws upon validated, objective evidence, and integrates the two sources into a unified vehicle for learning.

B. Action Research

The three publications put forward in this section represent the most important part of this overall doctoral submission. This reflects both the research subjects on which they report and the significance of action research itself in the contemporary health care environment. The continuous evaluation this essential approach offers to processes of policy formulation and implementation is particularly well suited to an epoch of rapid organisational change in the NHS. This change is leading to organisational complexities that increasingly invite and require the wide-ranging attention of social sciences' disciplines to unravel their current defining characteristics, and possible future consequences.

A series of recent professional researchers have developed wider feedback models of action research to apply in this context (e.g. Edwards and Talbot, 1994; Bouma and Atkinson, 1995). These have been explicitly applied to the research methodologies employed by the writer in his leadership of the collaborative studies examining the new public health and organisational interfaces of primary care, described in the publications *Mixing Oil and Water* [5] and *Relationships in the NHS* [6] issued during the 1999/2000 period. These two linked publications contribute to a new, broader-based approach emerging within the UK to applied health services research. In this approach the cyclical process of incremental organisational learning is directly built into the study. Design and support for social change through the regular supply of appropriate feedback and developmental aid, is accepted as a legitimate role for social research. Figure 2 diagrammatically illustrates this approach from *Relationships in the NHS* (p6).

The writer's first contribution of this kind to be included in this submission was the article entitled *Streaming into the River* [7]. This was published in the July 1999 refereed international Journal of Interprofessional Care. Derived from an extended study of primary eye care developments around the Camden and Islington health district, the action research approach supports the writer in not simply describing three alternative service models for primary eye care, but also, valuably, in defining a sequential, five stage framework for network based strategic development. This is reproduced in Figure 3 below.

Action Research Model

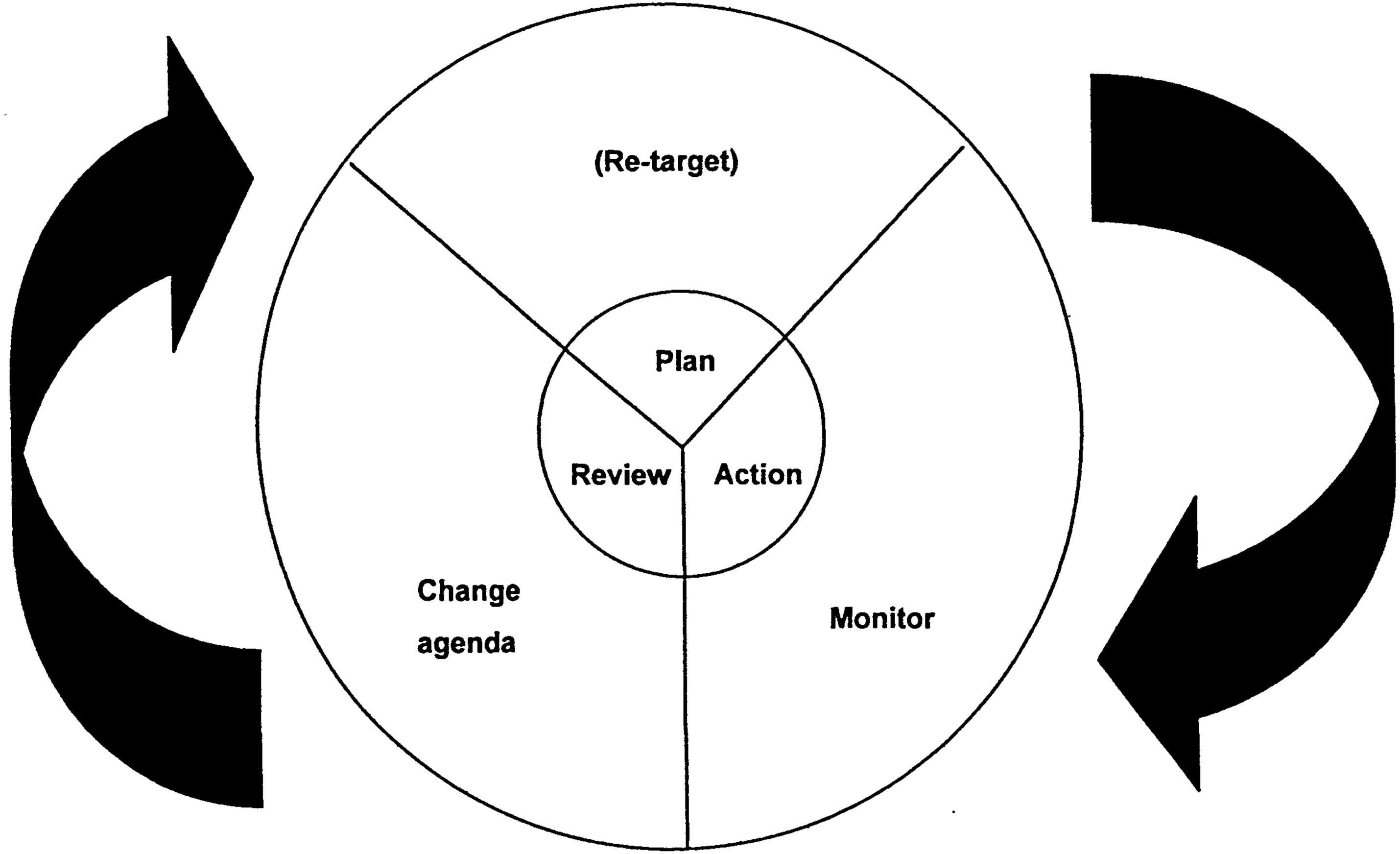

Figure 2

Source: [6, p6]

Camden and Islington: Network Based Development

The Five Stages, 1997-1998

i) Market Development - business collaboration on training, information and marketing to expand overall service sector

ii) Joint Training - based on common ground of maintaining clinical standards and maximising individuals' skills

iii) Specialist Accreditation - to legitimise development, and enlist support of key secondary care and academic 'leads'

iv) Shared monitoring and review - expanding peer mechanisms for professionals with management oversight to ensure overall compliance with health policies

v) Joint facilitation - by partnership between individual professional and executive representatives personally modeling approach to strategic change and acting as catalyst throughout service development.

Figure 3

Source: [7, p275]

The significance of this model is both its potential transferability from optometric to other Family Health Services initiatives, and its sensitivity in relation to the entrepreneurial and pluralistic features of UK primary care; to which typical theoretical constructs of rational or positional strategic development (e.g. Mintzberg, 1988; Parston, 1986) would be hard to apply appropriately with any degree of confidence. Action research is an ideal methodological vehicle for parallel organisational learning in which theory and practice interact in 'double loops' (Best, 1986) and, indeed, actually at times create each other. As such it has more often been used in the more flexible settings of education than with the NHS, where the reductionist school of thought has been the norm. For the same reason, however, the latter's General Practice sites have sometimes been the exception to this rule, described by one of its research teams, accordingly, as a 'marriage made in heaven' for qualitative studies (Murphy and Maltson, 1992). The complexities of contemporary primary care development require and respond well to action research.

Accordingly, in the study of primary eye care development, this interaction of theory and practice leads to five stages of strategic development being defined: collaborative market development, interprofessional training, specialist accreditation, integrated monitoring and review, and the joint professional/managerial modeling of change. These emerged as a single integrated analytical framework at the conclusion to the study, as well as singly as a series of concurrent contributions during the actual development process itself. Such models are helpful at a time when corporate strategic responsibilities for population health improvement, and for more effective individual health care are being located in primary care settings for the first time.

A similar value may be attributed to *Mixing Oil and Water.* This was the first research based publication in the UK to propose an organisational typology for the different kinds of primary care groups. It was developed as a result of the policy changes initially signaled by the Labour Government in its December 1997 White Paper entitled *The New NHS, Modern, Dependable* (Secretary of State, 1997). The research discovered radically new and different patterns of both internal and external relationships for primary care in England, as a result of which the NHS itself, as an organisational system, is being comprehensively re-processed.

In drawing upon a range of techniques and theories to help answer the question *How can primary care organisations improve health as well as deliver effective health care?* the

eclectic action research approach has the scope to combine, for example, thematic illustrative quotations from project participants, with the outcomes of local workshop and national simulation exercises conducted at the prescribed periodic review stages of the project, with the use of relevant management research concepts and theories, (e.g. Peters and Waterman, 1980) to help in the design of this continuous evaluation.

In health policy terms the product was both novel and powerful, with the Department of Health, for example, incorporating the recommendations in respect of local contracts for primary health care into its latest launch of Personal Medical Services pilots under the terms of the 1997 NHS (Primary Care) Act. Above all, the study identified more sharply than hitherto, the extent to which a central policy of decentralisation through primary care organisations also signified a move towards not only diversity but deregulation, because of the range of organisational status options available and accessed by those responsible for developing these organisations (5, pp 29-46). In so doing it pointed to the real tensions between national expectations of standardised provision and local communities' needs for different and distinctive services. At times, as the study showed, these tensions can become outright contradictions.

This lesson is simply one of several key areas of learning to be highlighted during the four-year action research project described in *Relationships in the NHS. Bridging the Gap* [6]. This book, published in January 2000, may be said to offer an original perspective through its analysis and assessment of the core functions of the contemporary NHS from the standpoint of their impact on relationships, as a result of changes arising from modern policy developments, particularly in respect of primary care. The action research cycle for *Relationships in the NHS* incorporates several of the ingredients of participant observation, management methods and case studies separately outlined in this submission. However, it is distinguished from these by its deliberate pitch to be part of the literature where social research is seen principally, and actively, as a source of social change. The change in society being targeted is that of a realignment of central policies for health and healthcare through the enhanced consideration of their impact on relationships in practice. This aim is particularly apparent in the final chapters of the book, with its concluding recommendations for NHS survival through enhanced local ownership and community commitments.

Relationships in the NHS takes as its premise for investigation social perceptions as social reality. It addresses the modern NHS as it is perceived to be, principally through a series of relationships assessment exercises, not as it is in plain structural terms, or as it is either said to be or should be in strategic statements. This is the premise that is the prerequisite for social research to act as the agent for social change. The research is a critical appraisal of events as they happened and as they were. It paves the way for the insights to emerge in the text which repeatedly highlight the distance between policy intentions and implementation, from the evidence of actual participants' - including the writer's and his fellow researchers' - experiences, as analysed in this action research project.

Accordingly, new and simple findings are brought forward which affect how the future development of the UK health and health care system is understood. The actual policy focus is on issues of commissioning and the secondary care interface, but the research points unequivocally to primary care relationships extending in the direction of social and community health services. Quality is promulgated by central policies as a comprehensive value, but in practice is understood essentially as political and expedient morality, with comparatively limited utility for organisational and clinical developments. In practice it is clear that personal and professional ethics require more sympathetic frameworks to harness their innovative and caring energies in productive relationships. Similar frameworks are required between the changing central and local boundaries of the NHS. The research indicates that in response to the 'Modernisation' agenda, there is a critical risk that genuine organisational learning at national level will inhibit Primary Care Groups and Primary Care Trusts becoming themselves modern learning organizations, because the central policies may allow them insufficient developmental scope and space. Above all the research approach, by pinpointing the fragility of relationships in an NHS, where development functions have been externalised and resource management responsibilities decentralized to the quasi-independent sector, raises questions about the viability of the future national organisation itself. The radical analysis of *Relationships in the NHS* is that of the need to create a nationwide rather than a national health service, legitimised by a range of localised and relationship-based systems of accountability.

This is a view that, of course, has been echoed in subsequent contemporary policy contributions (egs Dowell and Neil, 2000; Hutton, 2000). The writer himself is pursuing the specific, but broad recommendations made in Chapter Ten regarding, for example, the

impact of performance managing partnerships and the relational implications of combining financial allocation with service planning and delivery responsibilities in local settings. At present this involves a further applied health service research project examining, via local case studies, the management and organisational development of Primary Care Trusts (Meads, Meads et al, 2001). Action research projects, by their very nature, are never end products but inherently ephemeral in their accuracy. Their closing comments, as with *Relationships in the NHS*, should contain the opening terms of reference to the next programme of study.

C. Case Studies

As the last paragraph illustrates, case studies have a particular value when used as a research method at the early stages of a development which is intrinsically uneven or fragmentary, and the overall pattern is difficult to discern. Such case studies are often presented as models of good practice, where individual invention may be translated into more widespread innovation. As such, case studies are especially attractive to senior managers with professional backgrounds and development responsibilities; into which category the writer fell during his employment period of seven years with NHS organisations prior to joining City University in 1996. Hence the original interest in case studies, and their central contribution to three of the published papers which are now being submitted as part of the present application.

Indeed, the first of these, *A Primary Care-led NHS. Putting it into Practice* [8], was actually compiled prior to the writer's appointment with City University, although it was published subsequently. The writer was a NHS Regional Director of Performance Management whose research purpose was explicitly exploratory. The aim was to reach the point where a phenomenon was sufficiently understood to be described, so that it could then be measured or quantified (Mayer and Greenwood, 1980). This was particularly important for *A Primary Care-led NHS*, a policy slogan which initially attracted a generally positive popular response, yet lacked any clear sense of common understanding or a clear definition. This fragility and lack of intellectual rigour is addressed directly in the *Preface* where the writer recognises that a new national policy, running in parallel with a growing local diversity of primary care organisations, requires an essentially pragmatic response. It was important for the ownership of its developments that managers and professionals could re-create their own versions of a *Primary Care-led NHS* in every locality.

The writer's subsequent chapter *Communicating the message: what does it mean?*, then synthesises these local experiences, where 'variation is the norm' into a basic description of the subject area, defining a *Primary Care-led NHS* as essentially a different locus for NHS decision-making; the difference relating to where priorities for health care are agreed, and who takes part in this process (p12). From this definition, which at the time was quite at odds with the general perception of *a Primary Care-led NHS* as a product of GP purchasing, the broad properties of the phenomenon can be categorised. In this case the writer offers a new

four-fold classification of the distinctive leadership properties that apply to the new relationships between primary care and the NHS - local, relational, citizen-oriented and consumerist - as well as a five-tier hierarchy of strategic objectives drawn from his experience in Wessex.

In the writer's next edited volume *Health and Social Service in Primary Care: an effective combination?*[9] the writer again adopts the case study approach, 'as a strategy for empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence' (Robson, 1993). However, these case studies are pitched at a different level to those in the earlier text, with a conceptual framework of integrated development – clinical/professional, managerial, personal and organisational – which shapes the structure of the book and ensures that the material is appropriate to test the basic 'canons' of agreements and disagreement in relation to the subject title.

Case studies are of crucial importance to policy research and development. They can offer the opportunity to understand inductively causal factors through a wealth of information about practical effects, thereby reversing reliance on the usual positivist research model. To be of real relevance to policy development, however, such research must try to accurately analyse the subject to be described. Failure to do so results in posing the wrong questions on the wrong issues. Accordingly, in *Health and Social Services in Primary Care: an Effective Combination?* the writer's contribution in the first chapter, entitled *The Terms of the Debate,* deliberately seeks to 'pose the (right) question and then begin to determine the agenda for its response' (p3). This means tightly relating conceptual issues, with their potential conflicts, to the opportunities and obstacles described in the local case studies.

These issues are fundamental: is care indivisible or do the separate professions actually reflect distinctive human needs? Does devolved responsibility lead to professional convergence or divergence, and does this depend on the extent that financial and strategic roles are passed down? The context is described in the writer's Preface:

Levels of Primary Care-led Purchasing:

Climbing the Ladder

Steps:

1. Input from individual practices to commissioning priorities;

2. Input from groups of general practices representative of a District to its purchasing decisions;

3. Combinations of local Primary Health Care Teams (PHCTs) coming together to influence Health Authority decisions;

4. Local PHCTs compiling individual health plans for submission to the Health Authority to influence purchasing decisions;

5. Combinations of local PHCTs compiling one unified health plan to influence purchasing decisions;

6. Individual PHCTs compiling a health plan and being allocated indicative budgets by the Health Authority, but with purchasing still undertaken by the latter;

7. Combinations of local PHCTs compiling a health plan to influence purchasing decisions and bidding for contracts for shared services;

8. Individual PHCTs or groups of PHCTs compiling a local health plan and receiving allocations for the purchase and provision of agreed services;

9. Combinations of local PHCTs compiling a local health plan and social care plan receiving allocations from the Health Authority for the purchase and provision of agreed services. Staff may be employed within the PHCTs as Care Managers with a limited budget for social care; and

10. Combinations of local PHCTs compiling a local health plan and social care plan and being commissioned by the Health Authority and Social Services Department for the purchase and provision of agreed health and social care programmes.

Figure 4

Source: [10, p40]

(Compared with its predecessor) 'the present decade has taken a very different course. The advent of the health care internal market, the introduction of performance management, the growth of independent sector social care and more recently the drive towards a *Primary Care-led NHS* are creating very different conditions. The question this book explores is whether or not these are preconditions for the more effective combination of health and social services than has hitherto been available? Does the bringing together of NHS service development, financial control and clinical referral processes, when placed alongside the arrival of local social care managers, mean that the settings of contemporary UK primary care hold the key?' (p xiii).

The case studies that follow were commissioned to respond directly to this description of the policy problem or dilemma: the difficulties around, for example, substitution and nurse grading as a result of a new skills mix in Durham; the reluctance to convert unified budgets into unified staffing arrangements in Cornwall; and the time-consuming processes of collaboration in Dorset, each provide evidence to both confirm and explain the policy question posed by the writer. The case studies also contain good practice materiel and illustrate the writer's model for integrated development, described above, in Part III of the text. Above all, however, as the NHS Plan now recognises (Secretary of State, 2000; Chapter 7), they point to evidence that the new primary care developments are of themselves insufficient to ensure that central policy aims will be achieved. Such factors as professional communication and value structures remain unaffected, so the question of how to achieve effective combinations of health and social services continues to be valid, requiring further policy research and development in areas that the individual case studies help the writer to identify. *Health and Social Services in Primary Care: an Effective Combination?* accordingly provides a description of a subject through a sample of its cases that further studies can move on to measure and quantify. The action research projects outlined in Section B above, with their relational audits, are examples of such subsequent research.

The Chapter entitled *The Organisational Development of Primary Care* in J. Sims (Ed) (1999) *Primary Health Care Sciences* [10], is the final published paper submitted by the writer. This collates material from the case studies described above with a series of management frameworks, designed by the writer to help readers develop the new primary care organisations in their different locations. Figure 4 above contains an illustrative example of one of these analytical aids. Its comprehensive coverage of the subject is an appropriate

point at which to move towards a conclusion. The chapter traces the interaction between policy and organisational developments pinpointing the significance, at all levels, of the new relationship of direct encounter between the local and central interfaces of the health care system arising from the changes in primary care. Once again the thematic in this political analysis is the distinction between policy as expressed on paper and espoused by people themselves in practice through their organisational behaviour.

Conclusion

Recognising that contemporary primary care is politics, but also that it has the capacity to become defined as relationships has been, in summary, my original contribution over the past decade. This claim is the basis for the present submission.

The research described in the preceding pages supports this argument as a systematic body of study in which the methods employed have been true to the subject. The new phenomenon of primary care represents a complex organisational system, the development of which is best understood through multiple perspectives designed to explore and define potential as well as actual responses arising from adjustments to the organisational environment. This concept of 'phase space' (Griffith and Byrne, 1998) is a critical one to apply to contemporary primary care in situations where there is a demonstrable divide between the now largely linear assumptions of central policy statements and the decidedly non-linear actual behaviour of organisations. It brings meaning to complexity by clustering otherwise disparate variables and tracking trends. My published papers, I believe, help to sustain those wider arguments for a post-modernist approach to health services research being increasingly promoted by those looking to move beyond conventional scientific and epidemiological methods in understanding contemporary health care and its organisations (egs Robson, 1993; Petchey, 2001).

These papers make the connections between new policies and their ideas, with new organisations and their characteristics, and the new developmental relationships and management models they require. Seeing and making these connections has been my distinctive role.

Appendix A. Published works selected for PhD submission

[1] MEADS, G (1997) Power and Influence in the NHS. Oceans without Continents (Oxford: Radcliffe Medical Press).

[2] MEADS, G (1998) Integrated Primary Care: The Relational Challenge. In: Journal of Integrated Care, Vol 1, No 2; pp 51-54.

[3] MEADS, G (1996) Future Options for General Practice. In: British Journal of Health Care Management, Vol 2, No 7; pp 372-374.

[4] MEADS, G (1997) Getting it Together: Combining Health and Social Services. In: Community Care, Management and Planning Review, Vol 5, No 4; pp 141-146.

[5] MEADS, G., KILLORAN, A., ASHCROFT, J., and CORNISH, Y. (1999) Can Primary Care Organisations Improve Health as well as Deliver Effective Health Care? Mixing Oil and Water (London: HEA Publications).

[6] MEADS, G and ASHCROFT, J (2000) Relationships in the NHS. Bridging the Gap (London: Royal Society of Medicine Press).

[7] MEADS, G (1999) Streaming into the River. Network-based Development. In: Journal of Interprofessional Care, Vol 13, No 3; pp 271-276.

[8] MEADS, G ed. (1996) A Primary Care-led NHS. Putting it into Practice (London: Churchill Livingstone).

[9] MEADS, G ed. (1997) Health and Social Services in Primary Care: an Effective Combination? (London: F.T.Healthcare).

[10] MEADS, G (1999) The Organisational Development of Primary Care. In: J Sims ed. Primary Health Care Sciences (London: Whurr Publications).

Appendix B. Publications, Geoffrey Meads, post-1990 ctd.

Books

MEADS, G and ASHCROFT, J (2000) Relationships in the NHS (London: Royal Society of Medicine Press).

MEADS, G., KILLORAN, A., ASHCROFT, J., and CORNISH, Y. (1999) Can Primary Care Organisations Improve Health as well as Deliver Effective Health Care? Mixing Oil and Water (London: HEA Publications).

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Appendix B. Publications, Geoffrey Meads, post-1990 ctd.

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Appendix B. Publications, Geoffrey Meads, post-1990 ctd.

Articles in Refereed Journals

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Appendix B. Publications, Geoffrey Meads, post-1990 ctd.

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Appendix D.

Jointly Authorised Works

[2 (i)] G. Meads, A. Killoran, J. Ashcroft and Y. Cornish (1999). Mixing Oil and Water. How can primary care organisations improve health as well as deliver effective health care? HEA Publications, London.

This publication was the outcome of a collaborative action research project. Meads was responsible for leadership of the research team, including the design and facilitation of data gathering local workshops, site visits and simulation exercises and the analysis of organisational and policy developments in Chapters 3 and 4. Killoran prepared Chapter 1 and Ashcroft and Cornish jointly wrote Chapter 2. Ashcroft designed the relational profiling techniques in Appendices B and C and Cornish drafted the Health Strategy Framework in Appendix A. All assisted with the local workshops and with site visits.

[2 (ii)] G. Meads and J. Ashcroft (2000). Relationships in the NHS. Bridging the Gap. RSM Press, London.

This publication was the result of a jointly conducted action research project with its chapters written separately by each author. Meads wrote those entitled 'Agenda', 'Resources', 'Organisation', 'Development', 'Quality' and 'Prospects'; and the appendices. Ashcroft wrote those on 'Policy', 'Strategy', 'Delivery' and 'Review',. The Preface was co-written.

I agree that the share of the work of which I am joint author has been accurately attributed.

Name:

Address:

Signature:

Date:

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Signature: Anda Killoran

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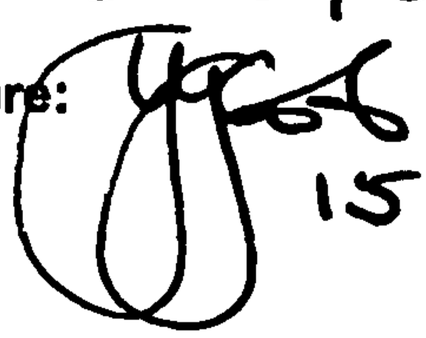
Signature: 

Date: 15 June 00