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Doctors in Management: A Study of Fundholding GPs

Julie Elizabeth Drake

A thesis submitted to the University of Huddersfield in partial  
fulfilment of the requirements for the degree of Doctor of  
Philosophy

The University of Huddersfield

Business School

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To the memory of my parents and grandparents

## **Abstract**

### **Doctors in Management: A Study of Fundholding GPs**

Fundholding enabled General Practitioners (GPs) to have financial responsibility for practice budgets to purchase health services for their patients. This thesis examines that significant episode in the history of the UK's NHS (Chapter 2) when independent contractors chose to be accountable as part of the creation of the internal market within the ethos of New Public Management (NPM). The reasons for practices electing to go fundholding are investigated, followed by examination of the implications of, and potential for, accounting in the management of fundholding at practice level through an empirical study of twelve fundholding practices in one region in England (Chapter 4). Accounting per se did not loom large, but in addition to significant findings on why practices went fundholding, the role of the lead partner for fundholding and why they took on that role emerged as a significant issue. Several years after the completion of the fundholding episode in the NHS, the GPs concerned were asked to reflect on its implications for their careers, in particular the relationship between their work as doctors and managers (Chapter 7). This brings a longitudinal element to the research.

This thesis is based on two major and one minor previously published refereed journal articles, together with further interpretation and more empirical work. The thesis structure reflects the emergent character of the overall research project (Chapter 3). After presenting the already-published research on why practices volunteered to go fundholding and how those practices selected their 'lead' partner (Chapter 4) and attitudes of GPs who took the management role (Chapter 6), a second analysis of the first phase of data is presented for the first time, finding different levels of engagement in management once fundholding was 'live' and evidence of doctors in primary care taking hybrid manager roles (Chapter 6). GPs are found to adopt different levels of engagement in management. The factors that contribute to doctors' engagement in management are identified. Accounting is found to enable doctors in management and assist them in securing notions of professionalism.

The study contributes to knowledge on a number of levels: it presents the case of an application of a NPM 'experiment' in an institutional setting recognising the context of general practice and financial responsibility as important in engaging doctors in management; it contributes to an emerging 'doctors in management literature', complementing the majority of that literature by focusing on primary care rather than secondary care. The study recommends that as doctors are increasingly being asked to get involved in the management of the finite NHS resource that fundholding was a significant episode to guide the design of policy and structures that will engage doctors in management. Future studies should investigate doctors in management, using case studies to examine the schemes in order to capture the 'lived experience', identifying the different levels of engagement, what they do and how they do it.

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# Chapter One

## Introduction and Background

### 1.1 Introduction

This thesis focuses on GP fundholding (DoH, 1989), a phenomenon that gave GPs budgets and responsibility to purchase services direct from the hospital. Fundholding is a specific episode that is important in the history of the NHS with a legacy beyond its years. This study contributes by providing insights and contributions; at a historical level for fundholding as the phenomena, where it documents and investigate fundholding in depth for the actors, the practitioners, therefore beyond a fleeting interest in the early stages of a short lived government policy; as an application of NPM (Hood, 1991;1995) in a different public sector segment; as an unusual applications of NPM, because organisations chose to go fundholding therefore electing for financial accountability and responsibility rather than it being imposed; how accounting may be implicated (Hood. 1991;1995) in that change (Hopwood, 1985; 1987); and, at the individual levels as GPs who are medical professionals first, involve themselves in management.

GPs are a collective of practitioners (a partnership) independently contracted to the NHS who could elect to go fundholding and become involved in the management of the financial aspects of the primary care system across the practice boundary by purchasing services. Alongside that responsibility went the allocation of practice budget and the inaugural marketisation of, and accountability for, their professional decisions. At first sight, fundholding may have looked like another application of NPM but because of its context it is far more interesting because its application was different to other application of NPM in the public services in the UK.

Fundholding, as a key change in the scope of financial responsibility for primary care was a prodigy of New Public Management (NPM), based in those reforms, seeking to make public services more accountable and increasing visibility on the premise that organisations were inefficient. It was unusual because it was voluntary and required

the talents of accountability and potential for accounting to create market efficiencies by creating calculable spaces (Humphrey *et al.* 1993) where accountability had not been before. In NPM a lot was said in the name of accounting, and what that mechanism could achieve (for example, Hood, 1991; 1995; Humphrey, 1994; Laughlin *et al.*, 1994; Llewellyn, 1998; Lapsley, 1999) when budgets were devolved within public sector organisations, e.g. hospital, police and probation services. Accounting as part of NPM reforms could contribute to the restructuring of the public services and the process of decentralisation and corporatisation (Lapsley, 1999) therefore it had a potential in the NHS (Lapsley, 1991). As NPM was rolled out so began a tranche of research: some in the name of accounting and accountability (for example, Broadbent, 1992; Llewellyn, 1998) and some in the name of management, for example, NPM in terms of *subject matter* (see Lapsley, 1999) and *institutional context* (Gray and Jenkins, 1986; Broadbent and Laughlin, 1997; Barzelay, 2001). Many of those changes involved accounting, sometimes accounting underpinned them (Mellett and Ryan, 2008) and thus accounting and fundholding are inextricably linked yet it was largely ignored in the studies of fundholding.

Thus, this doctoral journey began with the introduction of an apparently accounting-centric government policy. NPM stimulated research from an accounting and accountability perspective of the consequences of devolving budgets and opening up the visibility of organisations (for example, Humphrey *et al.*, 1993; Llewellyn, 1998, 2001) whose activities were not traditionally monitored by the devolvement of funds and budgets. Despite the accounting features and implications of enforced NPM appearing in the research literature for different institutions, little research appeared in fundholding despite its uniqueness: possibly for three reasons. Firstly, fundholding was a constituent part of the creation of the internal market in the NHS. Secondly, the research about the internal market neglected the social side of the organisations with a preference for market solutions and accountability patterns (Broadbent and Guthrie, 1992). Thirdly, fundholding existed in a small window of its operation (1991-1999) on a voluntary basis. The fundholding scheme differed not only because it required volunteers: firstly, GPs elected to be fundholding in a series of waves; secondly, not all GPs were eligible according to the rules for entry of each wave; and thirdly, GPs were independent contractors to the NHS and not employees. Participants in fundholding were taking part in NPM reforms not only as volunteers but also as

principals rather than employees on whom the reforms were imposed, unlike the hospitals, from whom GPs were to purchase services. This study is unique and important because it examines a different application of NPM– it is not the same context as reform in, for example, the hospitals, police or probation services. Further, the longitudinal study brings the legacy of fundholding to the fore, to add, contribute and develop to already published papers (Cowton and Drake, 1999a, 1999b, 2000), bringing new contributions presented here in this thesis for the first time.

There are two phases to the research. Phase one examines fundholding and its actors (GPs) in the institutional context (general practice) of going fundholding, punctuated by three publications (Cowton and Drake, 1999a, 1999b, 2000). This study shows fundholding studies were wanting because they concentrated on early waves so this study encompasses later waves, to present a more complete picture and analysis of fundholding. The study was based on the research assumption that, as in past institutional contexts, that accounting and accountability would be implicated in fundholding and would loom large and be important in fundholding. Accounting would be implicated in how actors lived the experience because it was the technique that would allocate the NHS funds more efficiently, effectively, and with economy if it were done by GP practices.

The study of the organisation and financial perspective in phase one revealed the importance of the individual (the GP) choosing to take a lead in management within the fundholding practice but their lack of interest in, or engagement with accounting as part of that role. Whilst GPs were taking management roles the implication of accounting for the scheme per se was less important than expected. It was evident that doctors were getting involved in management (Dopson, 2009) and based on that a second analysis of phase one data is conducted. The second phase of data collection after fundholding ended was a response to an emerging literature of doctors in management (including Cowton and Drake, 1999a, 1999b, 2000) and the findings of the analysis of phase one. The aim was to investigate the GPs who engaged in the management of fundholding to see if they continued engaging in management and if so how. A second set of research questions was designed to address the emergent importance of the lead partner.

The research focus became the role of the GP in management after three publications (Cowton and Drake, 1999a, 1999b, 2000). Moreover, doctors in management roles were being investigated by other researchers and the research was not without implication and challenge (Brazell, 1987; Bruce and Hill, 1994; Hunter; 1992; Buchan *et al.*, 1997; Rundall *et al.*, 2004). Clinicians in management were characterised as reluctant to engage in management in both secondary (Dopson, 1994, 1996; Fitzgerald and Ferlie, 2000; Witman *et al.*, 2010; Russell *et al.*, 2010) and primary care (Glennerster *et al.*, 1993; Greenfield and Nayak, 1996; Ennew *et al.*, 1998) which was at odds with the evidence from this study; fundholding was a choice as was the lead partner role, some were enthusiastic and some became more enthusiastic after the experience (Cowton and Drake, 1999a). There was a need to examine further how medical professionals engage in management by re-examining the original data. After reviewing the growing empirical literature, post-fundholding, to which the study had already contributed, a further analysis was conducted of the phenomenon of GPs choosing to get involved in management as a consequence of choosing the fundholding scheme. The analysis of the data from phase one shifted from the organisation (the practice) to individual (GP) to gain an understanding of why GPs became involved in management (chapter 4) and how they enacted that role (chapter 6). The important question here was if the role continued for doctors in the primary care setting, after the cessation of fundholding, and what factors contribute to that phenomenon. Since fundholding ceased there was an opportunity to see if doctors sought management roles after they had lost them. Therefore the second phase interview data was collected to examine the impact of engagement in management on doctors' career and if a management role was perpetuated (chapter 7).

## **1.2 Background to the Study**

By the 1990s public services in the UK had experienced successive reforms in the name of economy, efficiency and effectiveness, none more so than the National Health Service (NHS). The 'megatrends' associated with public administration (Hood, 1991) had pervaded the NHS including the reversal of government spending, privatisation (quasi or not), and introduction of information technology. One of the doctrines of such New Public Management (NPM) reforms was the disaggregation of the budgetary responsibility of units, to smaller geographically based units. Fundholding was a voluntary scheme central to the purchaser/provider split in the

National Health Service (NHS). The 'split' was largely attributed to Professor Alain Enthoven, a US economist, with funding allocated to resident populations, in this case the unit of general practice who would purchase health services, a defined range of hospital and community services, drugs and fundholding staff (Harrison and Pollitt, 1994). GPs could volunteer for shares of decentralised regional budgets awarded by the Health Authorities thus counteract the power of consultants and secondary care. GPs were deemed to be uniquely placed to manage budgets as the gatekeepers for the NHS, being closer to the patient and therefore the start of the process of healthcare.

The scheme began in 1991 and expanded rapidly in a succession of 'waves' of practices choosing to go fundholding. It was never compulsory though it has influenced, and continues to influence, compulsory models of devolved financial responsibility and resource allocation in primary care. By taking on board the responsibility for the resources and budgets, GPs were supported by a management allowance for staff, information technology support and the possible rewards of retaining surpluses on budget within the practice. Therefore in choosing to be fundholders the GP practices were choosing to be accountable through the mechanism and technology of the budget which was there to enable them to contract with secondary care providers as part of the purchaser /provider split.

### **1.3 Research Motivation**

Fundholding was implemented by government in order to improve the efficiency and effectiveness of public services by embodying key features of Hood's (1991) NPM and the doctrinal components therein (Hood, 1995). NPM is summarised by Osborne (2010): taking lessons from private-sector management; the growth of hands on management; focus on entrepreneurial leadership within public sector organisations; emphasis on input/output control, evaluation, performance management and audit; disaggregation of public services to the most basic unit (in this case GP as first point of patient contact); markets, competition, contracts for resource allocation. Thus fundholding embodies the principles of NPM, and is a response to it.

When applied to different segments of the public services, accountability gave visibility through delegation of control and reporting. Resources were dispersed into smaller units such as, hospitals (Lapsley, 1991; Broadbent, 1992; Laughlin *et al.*,

1992), the police (Woodall, 2004), and probation services (Humphrey *et al.*, 1993). Accounting was involved and therefore implicated in those changes, as accounting technology was an enabling and driving force by which the restructuring and operation of public services could be measured, negotiated and documented. Hood (1991; 1995) summarised the possible accounting implications of the NPM: more cost centre units; more identification of costs and understanding of cost structures; cost data becoming increasingly commercially confidential; private sector accounting norms; fewer general procedural constraints and more use of financial data for management accountability; more stress on the bottom line; more performance indicators and audit; broader cost centre accounting; blurring of funds for pay and activity. Thus it seemed that accounting would have implications and would be important as part of fundholding. It was thought important to add to the studies of differential impacts of NPM in differing segments (Lapsley, 1999) contributing by investigating it in this new institutional area. Further, the study provided opportunity to investigate a voluntary scheme unlike other sectors such as hospitals and the police where it was imposed.

#### **1.4 Research Aims**

The original, principal aim of this study was to investigate fundholding, why GPs chose to go fundholding and how accounting was implicated in general practice. GPs were independent contractors in private partnerships and the reform would make the world of general practice potentially more visible to individuals and organisations outside the boundary of the practice. Accounting would loom large in the accountability of general practice and it was important to investigate because this was the first time that accounting and budgets had pervaded general practice for the purpose of external reporting on resource utilisation within the practice. Fundholding introduced a funding allocation mechanisms and models where they had not been used before. It was the first time accounting had proximity to doctors' professional accountability although doctors may have been involved in general practice internal management.

The study is conducted from a subjectivist ontological approach and is interpretive using case studies of fundholding practices. Interviews were conducted with key players at practice level; the lead partner and fund manager. The findings from phase

one are analysed and presented, then re-analysed from an emergent perspective of the importance of the lead partner to give insights into what they did and how they did it. Though the role of accounting itself was found not important as a mechanism and part of the NPM, nor was it 'all but demonised' (Lapsley, 1999) as part of accounting change (Hopwood, 1985;1987). Accounting and budgets, underpinned (Mellet and Ryan, 2008) the purpose of fundholding, they were a consequence of choosing to be fundholders and were therefore implicated and thus, indirectly, impacted on what GPs did and how they did management roles. Asking GPs and fund managers about the financial accountability brings insight into the management role adopted by GPs as professionals. Thus the longitudinal study examines how the GP's management role is enacted in the community of accounting and further, how a management role might transcend the moment of fundholding and impact on the doctors' career by having a perpetuated role in management.

### **1.5 Research Methodology**

The research approach was essentially qualitative (Britten and Fisher, 1993). The initial units of analysis were GP practices in England and participating practices were recruited using a mixture of methods. Some responded to an invitation and leaflet which were mailed to several addresses on health authority lists. Others became involved as a result of recommendations or introductions from existing participants or some other 'champion' (Murphy *et al.*, 1992). The selection of practices was thus opportunistic, but there is a reasonable spread across different 'waves' - three 1st, one 2nd, five 3rd, one 4th and three 6th<sup>1</sup>, suggesting that many relevant issues are likely to be picked up from the interviews. Indeed, one of the striking features of the findings is the range of experience and opinion found across the sample. It is one of the few empirical studies of the fundholding period that extends beyond the early waves in data collection.

The interpretive research philosophy (Saunders *et al.*, 2009) from a subjectivist ontological view aims to explain what was occurring in general practice in order to investigate the meanings attached to going fundholding and investigate how

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<sup>1</sup> Beginning on 1st April 1991, the implementation of fundholding proceeded in a series of annual 'waves'. The first wave set a minimum patient list size for fundholding applicants of 9,000, but subsequent waves gradually reduced that requirement.

accounting was implicated. The research explored and thus identified points of significance. Even if it is not possible to estimate how representative participants' views in this study are of the wider population of fundholding practices, or to claim to have exhausted all possible issues and perspectives, the study provides an in depth examination in the peculiar context of fundholding as a consequence of NPM and GPs engaging with management. Typical of a qualitative research study, the research does not seek population generalisability but it does add to the body of knowledge and understanding of how this group of professionals got involved in financial accountability and acted out management. The study provides visibility and interprets the phenomenon of fundholding in the context of how GPs carved out a management role.

The first phase of the research has its origin in NPM and associated reforms. GP fundholding was voluntary and raised two key research questions;

**RQ 1 Why did the practice choose to go fundholding?**

**RQ 2 How was accounting implicated in the management of fundholding?**

Accounting and accountability per se failed to loom large in the interview data, but the interpretive approach bore two further sets of research questions that contribute to the understanding of how doctors engage in management as a result of the reform;

**RQ 3 Why did the lead partner undertake that role?**

**RQ 4 How did the lead partners enact the management role; what did they do and how did they do it?**

The demise of fundholding brought an end to the GPs' opportunity for volunteering for management as lead partner of a specific scheme and raises questions of professionals choosing a later management role. Therefore additional research questions address under what circumstances that engagement in management may be perpetuated and the impact on career;

**RQ 5 Did lead partners continue to engage in management after fundholding, and if so, how?**

**RQ 6 How did lead partners' careers fare after fundholding?**

Twelve practices yielded case studies in phase one of the study based on semi-structured interviews with the lead partner and fund manager within each practice. Of those twelve practices, six lead partners were interviewed for phase two of the research.

### **1.6 Initial Findings: Going Fundholding and the Role of Accounting**

The main findings from the initial research questions were the clear identification of dominant and multiple reasons for going fundholding for each practice, thus addressing the first research question. The interviews bring more knowledge of the factors supporting the choice to go fundholding than previous studies. However, in respect of the second question, the role of accounting per se did not loom large for the practice, the lead partner or the fund manager. What did emerge strongly from the data in this study was the significance of the lead partner and because accounting was implicated in fundholding it was therefore implicated in the professionals (GPs) choosing a management role.

The second set of research questions investigates GPs in a new management role and what sort work they did and how they did it. The publications (Cowton and Drake, 1999a, 1999b, 2000) revealed the significance of the lead partner taking on board a management role and debated the prospects beyond fundholding for GPs in management roles. However, the publications did not go far enough, based to some extent on debate and conjecture, and while the first and third question loom large in the publications from this study there so much more that needed to be asked of the data. Therefore the thesis continues the story and explicates the legacy of fundholding, the implications of accounting in the management of it, and investigate the management roles and careers of fundholding GPs. Therefore the second phase of the research builds on the first phase by taking a different direction in order to understand and contribute to the literature on, and legacy of, fundholding beyond the three publications, and as such is presented for the first time in this thesis.

## **1.7 Doctors in Management**

A literature review of doctors in management (chapter 5) was conducted in order to support a secondary analysis and in-depth investigation of the first phase interview data to explain why doctors engaged in management and how they enacted the role they had adopted. It was found that there were limited empirical studies of doctors in management roles, the majority of which were in the secondary care setting of hospitals (Brazell, 1987; Bruce and Hill, 1994; Dopson, 1996; Hunter, 1992; Buchan *et al.*, 1997; Rundall *et al.*, 2004); Kirkpatrick *et al.*, 2009; Neogy and Kirkpatrick, 2009). The literature findings and recommendations were largely normative, that is, what GPs ought to do in management and how they might go about it (for example, Clark and Armit, 2008). The literature was repetitive in its recommendation that the way to get doctors engaged in and successful in management was by education through incorporation into the medical school curricula or through post-qualification courses (Newman and Cowling, 1993; 1994; Allen, 1995). This meant that it was important to revisit the original interviews to establish why the doctors engaged since few studies asked GPs who were actually in management roles.

The literature in secondary care debated the notion of a hybrid manager. This study contributes by examining in more depth the choices in management made by doctors in the primary care setting. Further, through additional analysis of the evidence, the engagement of GPs in management is interpreted in order to make sense of the phenomenon. Based on this notion of a hybrid manager the ‘choices for the manager’ framework (Stewart, 1992) is used to interpret and make sense of what the GPs as managers chose to do and the way they did such things in order to establish how GPs enacted their management role and to what level alongside their primary profession. In this study the hybrid manager is conceptualised as strong or weak and the factors that influence the degree of engagement in management are modelled.

## **1.8 Doctors and Career**

This study provides insight and evidence of how professionals who volunteer for management engage. Moreover it was found from the original interviews that once involved those volunteers enjoyed it - even GPs who were reluctant at the outset of the scheme became more engaged with it. This contrasts to doctors as managers in

secondary care who were found to be reluctant and often did not perpetuate a career in management and who actively sought to return to doctoring. Therefore the second phase of data collection examines if doctors who were lead partners continued to engage in management after fundholding, if so, how and how did lead partners' careers fare after fundholding?

## **1.9 Thesis Structure**

The thesis is organised into eight chapters and is presented in an unconventional way. It is a confessional and trustworthy account of the research process, key stages and findings. This chapter, *Chapter One*, is introductory providing the background to the study, research aims and research methodology. It explains the original motivation for the research and how the initial findings, as published, impacted on the research journey to contribute in a different context, to doctors in management.

*Chapter 2* defines NPM and discusses the ethos behind the design of fundholding. It identifies and considers the different perspectives of accounting change using a seminal model of accounting change (Hopwood, 1987) to assist in understanding the potential implications of accounting in fundholding. The historical context of the fundholding is examined to build up a model of the factors shaping its design. As empirical studies emerged during fundholding these are identified and critically evaluated to identify any shortfalls in the analysis of fundholding. Finally, the chapter identifies the literature on going fundholding in the context of accounting to position the research questions (1 and 2), why did practices go fundholding, and how is accounting implicated in the management of fundholding?

*Chapter 3* describes the method of inquiry and theoretical approach presented as a confessional account of the research. It explains the time horizon, research strategy and research choices. The chapter has four key objectives in order to tell the story of the research strategy. Firstly it provides some assumptions that inform the methodology explaining the qualitative researcher as the 'bricoleur'. Secondly, it provides detail of the method and how the field work was conducted for the first phase of data collection. Thirdly, it explains the rationale and emergence of the second set of research questions which are applied to the phase one data, to explain and justify the empirical inductive approach. It describes the research method for

phase one and further, how the methodology evolved to analyse the phenomenon and emerging themes from phase one into phase two to make sense of the data. Finally, as a prologue to the forthcoming chapters, it explains the purpose of the second phase of research.

*Chapter 4* presents the results and analysis of the phase one interviews. It explains why the practices in the sample went fundholding and how they chose the lead partner. The role of accounting per se is found not to be important (Cowton and Drake, 1999a). Accounting is found to be instrumental to the design of fundholding and its objectives, enabling visibility, governance and, if chosen, participation in management by doctors. The background leading into becoming lead partner is found to be important rather than the organisational reasons for going fundholding. For the first time a study unpicks the seam between organisational reasons for fundholding and individual lead partner reasons for taking the role and seeks to interpret and explain the phenomena. The engagement in management for the GP becomes an important issue (Cowton and Drake, 1999a). Engagement in management by the GPs leads firstly, to further questions about why GPs became lead partner, hence involved in management and it leads secondly, to how did the doctors in primary care enact that role? The importance of the prospects of GPs engaging in management of the NHS was further recognised in the second publication from the study (Cowton and Drake, 1999b), concluding that careful attention therefore needs to be paid to the assumptions being made about the motivations and priorities of doctors engaging in management, (Cowton and Drake, 1999b). The emergent third question is analysed more deeply in the thesis to categorise why lead partners took that role.

*Chapter 5* presents an overview of the empirical literature of doctors in management. The literature presents the case for a second analysis of the phase one data as there are gaps for doctors in management of primary care. Prior to 2000 there was little empirical evidence of doctors in management and the opportunity is taken to evaluate fundholding legacy of engaging doctors in management by expanding the analysis and data.

In *Chapter 6*, the phase one interview data are analysed for a second time order to examine how GPs enacted the role in order to add to the doctors in management

literature to address research questions four. The framework to analyse what doctors did and how they did it, that is, the engagement of doctors in management is presented. The data are analysed and a case study for each lead partner is constructed to enable comparison of data on doctors in management in primary care to doctors in management in secondary care for the first time. It identifies the factors that influence engagement in management roles and present levels of hybridisation.

*Chapter 7* outlines the research method for the second phase of data collection and presents the case studies for each GP. The analysis reveals how the careers of the doctors who chose management have developed after fundholding ceased. It considers if a career in management continues, or for those who did not engage in the first place, if one develops. This study contributes to the literature from a different perspective by examining the individual doctor in career beyond their initial foray into management. Interviewing the lead partner enabled investigation of what the careers of the doctors who chose management look like and if they continue to choose management. Further, it identifies the satisfiers and dissatisfiers from having been a doctor in management as consequence of engaging in fundholding.

Finally, *Chapter 8* summarises the research findings from both phases linking together the journey to identify limitations and draws conclusions with the researcher as ‘bricoleur’. The chapter comprises five sections: the first summarises multiple reasons for practices going fundholding, the significance of the lead partner and a typology developed to explicate why GPs take a lead role; the second explains the role of accounting, accountability and its interplay with management activity; the third covers the findings of this study relative to the doctors in management literature and the Hybrid Manager Engagement Model (HMEM); the fourth identifies some limitations of this study and the opportunities for further research; and, the final section identifies the principal contributions.

## **1.10 Conclusion**

This chapter has presented the subject of the thesis, introduced the contributions of the study, and explained the two phases of the research and the trajectory of the levels of analysis from fundholding practice to individual GPs in management. The background to fundholding, underpinned by accounting and accountability as

motivation for the study is explained. Glimpses of the story unfold as the legacy of fundholding is revealed and addressed through the outline of the research methodology and sequence of emergent research questions. Some of the contributions of the research are noted in this chapter that have already been published in refereed journals, however based on a second phase of research, further contributions are presented in this thesis for the first time.

## **Chapter Two**

### **Fundholding**

#### **2.1 Introduction**

The purpose of this chapter is four fold: firstly, it explains the ethos behind the design of fundholding including defining NPM; secondly, because fundholding was based on accountability and accounting it considers the different perspectives of accounting change using a seminal model (Hopwood, 1987) to understand the implications of accounting; thirdly it considers the historical context of the fundholding by examining GPs relationship to the NHS to facilitate understanding of why fundholding looked the way it did and to assist later analysis; fourthly, it identifies the literature on going fundholding in the context of accounting.

#### **2.2 NPM: An introduction**

The first section introduces NPM to contextualise NPM research in the institutional setting and justify the examination of fundholding as one of the NPM ‘experiments’ (Broadbent and Laughlin, 1997). It recognises the common characteristics of NPM – accountable management at the point of delivery signalled by the introduction of budgets and therefore implications for accounting. It considers the role and importance of accounting as part of NPM and does so through the lens of accounting change (Hopwood, 1987) to consider its potential. The second section explains General Practice from a historical perspective to properly contextualize this study, helping to understand fundholding better and be able to analyse and interpret findings in that healthcare context. The third section identifies the literature on why practices went fundholding and the organisational impact of the reforms in the context of accounting for those reforms.

Hood (1995) explains that NPM replaced progressive public administration (PPA). Public administration (PA) emphasised policy with a strong public sector ethos based on two doctrines of contrasting the public and private sectors and thus clearly defining them:

*One of those doctrines was to keep the public sector sharply distant from the private sector in terms of continuity, ethos, methods of doing business, organizational design, people rewards and career structure...the other doctrine was to maintain buffers against political and managerial discretion by means of an elaborate structure of procedural rules... (Hood, 1995, p.94)*

PPA presented a philosophical and practical divorce between the operation of the public, compared to the private sector. PPA was grounded in duality, presented in the contrast between the public and the private sector with ‘inextricably interrelated terms developed alongside one another’ (Llewellyn, 2003). In sharp contrast PPA was followed by NPM bringing private sector principles into the public sector. For example, NPM introduced competitiveness with contract based provision seeking efficiencies and the implication of private sector management styles. A broad empirical literature developed from the application of NPM with two key themes, the *institution* it was applied to and the *subject area impact* of NPM in the context of that institution (Barzelay, 2001) e.g. human resources.

This chapter does not seek to provide a full literature review of the subject matter and institutions NPM doctrines touched, but it does aim to contextualise NPM’s impact on general practice and draw from the literature surrounding and pertinent to fundholding. Lapsley (1999), referring to the nature and role of accounting practices in NPM, noted that they were based on “the focus of quantification (i.e. what is more tractable for measurement purposes, ” (p.206, Lapsley, 1999) and hence the primacy of accounting, for example, capital charging, the Private Finance Initiative, competitive tendering, cash to accrual accounting and financial management efficiency. Further, he argued for revisiting the paradigm of NPM for its meaning for key actors to establish broader and substantive efficiency gains rather than focus on the micro-efficiency gains which had not been found in research studies. Fundholding sought large scale NHS efficiencies as part of the internal market. Accounting change was evident in general practice by the introduction of budgets creating accountability as part of overall plans for organisational improvement in the NHS, thus the implication of accounting in the management of fundholding as perceived and acted out by GPs is an area to study as important as the other manifestations of NPM in other segments of the public sector. As a voluntary scheme it is necessary and valuable to investigate the scheme, as it was unusual then, and especially when more

recent schemes, such as trusts in the health sector and free schools and academies in the education sector, are being promulgated.

### **2.2.1 NPM: Studies in the Institutional Context**

NPM experiments were examined in different organisations because of resource management implications, the potential for impact on and, reaction of, individuals in the organisations and the consequences of implementing mechanism to meet the aims and objectives of NPM. NPM had various descriptions and applications and multiple implications dependent on its context. Osborne (2010) recently summarised the breadth of applications: taking lessons from private-sector management; the growth of hands on management; focus on entrepreneurial leadership within public sector organisations; emphasis on input/output control, evaluation, performance management and audit; disaggregation of public services to the most basic unit (in this case GP as first point of patient contact); markets, competition, contracts for resource allocation. There are many examples of NPM and how it is portrayed in the literature because of a lack of agreement as to what NPM constitutes which caused Hughes (2010) to conclude that its most salient points and its worth are found in how it *impacts* the organisation rather than debate about what it might constitute as a system or programme. NPM was about a change from administration, moving to a top down approach, and to the introduction of management. Accounting was present in order to bring about accountability at service delivery level thus NPM was practised at a practical rather than theoretical level. It may be that NPM did not develop as a theory because it was based on the practical process of accountability. Concepts such as accountability that reflect practices have not generally been thought of as ‘theories’ (Llewellyn, 2003) such that “practice-theory dualism is impeding any understanding of the “theory- status” of any concepts rooted in practice” (p.674). Indeed Broadbent and Laughlin (1997) described NPM and the changes it brought as policy experimentation and highlighted the failure of government to evaluate the NHS reforms in particular. Thus NPM as a bundle of policies and ‘experiments’ became a significant term in the literature. There was no universalist approach to the study of the manifestations of NPM therefore perhaps it has been overlooked for the phenomena it was because it was not consistently and strategically implemented or studied. Under these circumstances it would be difficult to generalise about NPM but valid to investigate each case of its application in situ. Therefore, the fact that many

reforms were not evaluated as part of a wide-ranging universal programme leaves individual research studies to document these ‘experiments’.

Gray and Jenkins (1986) also recognised the need to contextualise NPM by institutional application. NPM had theoretical roots (Osborne, 2010) in rational/public choice theory and studies emphasised the management of organisation resources, organisational performance and the implication for performance management of individuals within the organisation, for example Butterfield *et al.* (2004) in the UK police force. The police also received attention where the subject focused on the impact on individual roles for those already in management, for example Butterfield and Edwards (2005) – NPM from the perspective of change. Research did not follow the study of a grand policy experiment, but application in miniature to specific institutions yet no attention had been paid to fundholding and the implications of accounting and its role in fundholding until this study.

In some public sector segments there were studies of organisations and individuals which looked at the consequence of implementing NPM and its *mechanism*, for example, Laughlin (1991) looked at the information systems in the NHS that were required as a result of the implementation of the internal market. Similarly, as accountability was a key feature of NPM, accounting was studied as part of the mechanism for change. This study views accounting as part of the mechanism for change under the universal characteristics of NPM. It aims to examine fundholding and the implications of accounting for the management of fundholding as part of the change brought about by NPM reforms and concurs with an intra-organisational perspective of studying NPM, hence avoiding a universalist approach (Gray and Jenkins, 1986). Some studies concentrated on the impact of delegating financial responsibility (see Humphrey *et al.*, 1993; Llewellyn; 1998 and 2001) when the mechanism of accounting makes visible the activities which generate costs. Those studies are consistent with Lapsley’s (1999) concern that focus on measurement and input and output could lead to “irrationalities or at least inhibit the fusion of management ideas and the actions of key groups in the organisation”, (p.206). Fundholding involved the delegation of budgets to GPs, presenting a different institutional setting for studying these accountable management changes. Therefore

accounting as a conduit for NPM reform suggests change and accounting needs to be considered as part of that change.

### **2.2.2 Fundholding: Creating New Territory for Accounting**

Fundholding was based on concerns of value for money and efficiency as part of the larger internal market initiative for the NHS. Resource management was key and there were a number of 'accountable management' reforms (Humphrey, Miller and Scapens, 1993). Accounting and its practice had been documented in the probation service (Humphrey *et al.*, 1993; Humphrey, 1994), the social services (Llewellyn, 1998) and the police (Woodall, 2004). These were services where accountability had not been delegated to smaller units at the bottom of the hierarchical services before; hence financial accountability had not loomed large. This is in contrast to the large organisational bodies within the public services such as hospitals which, traditionally, used financial and management accounting. Humphrey *et al.* (1993) considered the application of budgets in these new scenarios as "accounting technologies, of calculable selves and calculable space loosely linked to each other and to a centre of calculation provides the possibility of acting on the actions of other, guiding individuals without the need for direct control or supervision," (p.17). Like Gray and Jenkins (1986), Humphrey was also critical of the folly in the universalist approach which implies there was more to learn from considering the application in context. Thus it seems that NPM was a 'loose' term featuring accountability to a lower denomination, a new calculable space (or unit) reporting up to a centre of calculation. Thus there was a need to study accounting in context in a new and original calculable space – 'new' in the content of not being accountable in a previous structural and administrative form. Moreover, Humphrey *et al.* (1993) were proponents of the study of the 'lived experience' of individuals who were applying the accounting technologies rather than technologies themselves, unlike Laughlin (1991) looking at the mechanism aspect as part of information technology. This consideration of the role of accounting as part of the accountable management reforms has common ground with the work of Hopwood (for example, 1978; 1983; 1985; 1987) who called for accounting research to go beyond the technological aspects of measurement and calculation and be considered for its organisational and social impact. Fundholding placed accounting in new territory, with a new purpose, recording and measuring new forms of financial activities and opening up accountability and visibility.

The implications of accounting, the roles and technologies, and how that might be implicated in change had been extensively debated and summarised in a seminal paper on the archaeology of accounting systems (Hopwood, 1987). A paper reviewing existing perspectives of accounting change created a useful framework for establishing how the role of accounting might be considered in fundholding because fundholding was “putting accounting where accounting was not” (Hopwood, 1985, p.214). This was not only a case of accounting going to a lower denomination and smaller unit for accountability purposes but to a brand new organisational setting to be used to make persons accountable beyond their organisational boundary. Previously, general practice was effectively a small business independently contracted to the state. Thus accounting and budgets for GPs could be studied as a ‘lived experience’, unlike Hopwood, who had to resort to the history of Wedgwood from the 17<sup>th</sup> century, to “witness the birth pains of newly emergent accounting” (p.214). Table 2.1 summarises the four perspectives on accounting change, as opposed to accounting being static, the features of accounting change and the paradigm strengths and weaknesses. It is presented here to “enable a more dynamic understanding of the accounting craft” (p.209) and will be used as a frame to consider the role of accounting in fundholding.

The four perspectives (Table 2.1) show what might be expected that the role of accounting change could be in an organisation. It suggest that accounting; can be a technique to facilitate organisational improvement, that it can enable and improve in an organisational performance for example, assisting decision making and goal congruence in the NHS at large; that accounting practice implements change to construct organisational order, for example, implementing budgets, with the associated tensions and possible dysfunctional consequences; that accounting can be a practice that creates social order, for example, enabling more governance and control; accounting can be in motion, when in action it can transform organisations.

Figure 2.1 describes the process of accounting in ‘experiments’ such as fundholding. The role of accounting is to assist in improving the economy, efficiency and effectiveness as knowledge would not stand outside of accounting. The practice is given a budget and purchases or designs accounting technology to meet the requirements of being a fundholder.

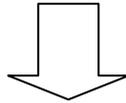
<b>Perspective</b>	<b>Features of Accounting Change</b>	<b>Paradigm Strengths and Weaknesses</b>
Accounting and <b>Organisational Improvement</b>	Organisational change and improvement. Accounting more than a technique, it is concerned with what accounting should be and conceptions of the potential of accounting. Accounting as part of the process of direction, planning, decision making, control and the management of motivation. Accounting as enhancing organisational performance such that economy, efficiency and effectiveness can be improved by accounting. "Knowledge does not stand outside of accounting" (p. 210).	Recognises accounting is more than a technique and its capabilities. On the other hand, presents a history of inadequacy of accounting with a focus on what it should be. Ignores the development of accounting and the duality of the interactions; accounting needs to be recognised more for creating rather than enabling.
Accounting and the <b>Construction of an Organisational Order</b>	Research focussed on accounting practice. The analysis and understanding of accounting practice recording organisational tensions, resistance and dysfunction. An advance in research in that "accounting has at least been grounded in the organisational context in which it operates" (p.212) thus a growing understanding of practices of accounting.	Not enough focus on accounting change. Dysfunction recorded but not re-appraised in order to change the craft of accounting. Accounting as imposed with little recognition of 'management discretion and choice'. Comparative studies, "accounting seen as it was and as it is rather than in the process of becoming" (p.212). Lack of recognition for shaping organisational affairs. A negative account rather than a positive process so that it becomes what it was not.
Accounting and the <b>Construction of a Social Order</b>	Accounting creating economic visibility. Visibility enables governance and control of the organisation. Accounting as an "artefact residing in the domain of the social rather than the narrow organisational" (p.213). Purposive and purposeful; "making real by the active construction of the organisation as we know it, interests which are independent of both the accounting and the organisational representation of them," (p.213).	Accounting no longer seen as passive and neutral, not merely a technical instrument of administration. Early beginnings for recognising accounting practice as in motion.
Towards a view of <b>Accounting in Motion</b>	Accounting in action. Precise mechanisms of accounting change. Accounting playing a role in transformation in organisation.	Would recognise the organisational and the social and "appreciate how accounting might enable the concerns of the social to pass through and thereby transform the organisation and, in turn, to create organisational practices which can be influential in the construction of the world of the social" (p.214).

**Table 2.1 Four Perspectives of Accounting Change Source: Hopwood (1987)**

Therefore questions arise about the role of accounting in that new situation and the implications for the fundholders themselves. There are expectations about what the structure and mechanism of accounting as part of fundholding will achieve in this new

setting that cannot be explained with reference to other applications of accounting. It is presented to construct organisational order as part of the internal market but it is not imposed and hence there is choice.

Implement the Accounting Technology



Accounting in Practice

**Figure 2.1 The Role of Accounting in Fundholding – at the simplest level**

### **2.2.3 NPM: The Implications for Accounting**

The purpose of this research is to investigate why practices chose to go fundholding (research question 1) and what the implications of accounting are for the management of fundholding. Fundholding is an application of NPM with accounting technologies central to achieving the objectives of fundholding and there are implications of accounting in this context of change. Hood (1991, 1995) summarised the possible accounting implications for NPM: more cost centre units; more identification of costs and understanding of cost structures; cost data becoming increasingly commercially confidential; private sector accounting norms; fewer general procedural constraints and more use of financial data for management accountability; more stress on the bottom line; performance indicators and audit; broader cost centre accounting; blurring of funds for pay and activity. However, these are practical implications for accounting. All of these implications are about the structure and mechanism of accounting before it is applied in the accountable context of the organisation and whereby it then becomes a lived experience by the individuals. NPM's aspiration for accounting was for organisational improvement at the level of the NHS, and as an enabler to construct organisational order at practice level. It is important to explicate that experience in order to understand if, and how, the role of accounting might be important in fundholding with possible practical implications; what was the role of accounting in the management of fundholding (research question 2)? NPM as accountable management seeks organisational improvement; economy; efficiency;

effectiveness in public service bodies, reducing the gap between the public and private. NPM has a universal assumption that it will improve the organisation, in this case the NHS. The improvement sought could not be achieved without the accounting function therefore what role does accounting actually have for those involved? The aspirations for fundholding, the knowledge required to make its purpose successful could not be achieved without accounting – it enables the process of fundholding.

#### **2.2.4 Implementing Accounting in the NHS**

Accounting implications of NPM emerged in the literature, for example, Glynn *et al.*, 1992; Humphrey *et al.*, 1993; Humphrey, 1994; Laughlin *et al.*, 1992; 1994; Llewellyn, 1998. The findings of those studies were commensurate with the second perspective, summarised in Table 2.1 as accounting and the construction of organisational order. Studies examined the organisational context e.g. police, social services, health service. Thus while the motivation may have been organisational improvement at public service level (NHS) the accounting change brought about organisational tensions, resistance and dysfunction in smaller units within the hierarchy. This was observed and written about in different organisational settings. It seemed that financial control and budgets brought about negative accounts of the implementation of accounting in practice.

Accountable management reforms (for example, Humphrey *et al.*, 1993; Glynn *et al.*, 1992) suggests that the research outcomes reflected Hopwood's (1987) second perspective of accounting change and the construction of an organisational order (see Table 2.1). Studies focussed on the dysfunctional consequences of such practical applications on organisational life. They questioned if the missions, goals and objectives of the organisation to which they were applied can be changed (Laughlin, 1991a) or whether any benefits are derived for the 'consumer' (Mayston, 1993).

Laughlin and Broadbent (1991) and Laughlin *et al.* (1992; 1994) investigated the 'financial management initiative' (FMI) within the NHS. They described "devolution of financial responsibility to allow freedom of financial management yet at the same time a heightened intrusion into defining objectives to be achieved and detailed requirements of an accountability nature with a particular emphasis, wherever possible, on the measurability of outputs" (Laughlin *et al.*, 1992). These studies found

that the accounting change initiatives involved tensions such that the changes could cause damage and danger for the profession of general practice and involved compulsory changes within the 1990 contract rather than voluntary changes. Laughlin *et al.* (1992; 1994) generally took a wide view of accounting with the study of the organisational changes for both non-fundholding and fundholding practices viewing financial and administrative changes as accounting led whilst choosing not to concentrate on the largest accounting led change to general practice – fundholding.

Lapsley (1991) forecast the potential for accounting in the NHS broadly; the future extent of accounting (increasing); the resultant need for research in the NHS in the context of potential conflict of accounting with the values and norms of medical services. Research on healthcare and budgeting has frequented the literature in the context of NPM reforms, mainly in the setting of hospitals for example, Lapsley (1994), Kurunmaki (1999), Doolin (2001), Nylan and Pettersen (2004), Macinati (2010). Lapsley's (1991) premonition on future research potential was pertinent for the implications of NPM led reforms for general practice as he agreed with Bevan (1989) that the GP would be a pivotal element in NHS reform and the creation of the internal market. Fundholding was there to make the market work with purchaser (GP)/ provider (hospital) split. For that aspect of reform to work GPs had to be encouraged to take on the role of purchaser of services rather than a service instigator who had unlimited access and funds, uncontrolled referral behaviour and no mechanism for monitoring. Broadbent (1992) observed the accounting implications in the NHS suggesting that accounting had a central role in the changes in the NHS as part of the design archetype, "the tangible manifestation of the interpretive schemes" (p.347). Could the interpretive schemes (norms, beliefs and missions) of traditional general practice be changed and given more order? Could accounting construct that social order (beyond organisational order) and might it become important in the organisation as a key contributor to NPM 'philosophy' for efficiency and effectiveness? Thus taking all of these views on board, Hood's (1991, 1995) NPM implications for accounting and the perspectives of Hopwood (Table 2.1) it is suggested here that professionals in the public sector could no longer assume that financial and accounting systems were principally passive and a bureaucratic means of recording financial consequence of their professional judgement ( Ezzamel and Willmot, 1993). Accounting change was implemented to create accountability which

also meant visibility and needed to be studied and interpreted in the fundholding context. NPM change was about creating accounting in a new context as part of the internal market and the researcher here contends that accounting may not be passive and requires investigation in this institutional context. Accounting was introduced where accounting and budgets across organisational boundaries had not existed before, because of the internal market. Therefore questions need to be asked and analysed in the context of the role of accounting in going fundholding.

This section has introduced the broad concept of NPM and justified the need for an investigation of fundholding as an example of an accountable management reform. Hopwood's (1987) perspectives of the possibility of accounting change raise questions, not least because fundholding puts accounting where it was not, making it purposive where it has not been before and opening up the possibility for accounting change. The perspectives will help the analysis and debate. This study is justified in bringing fundholding in focus, as an experiment of NPM, for three reasons: firstly, the GP is an independent contractor and not an employee of a public service unlike the police, social and probation services; secondly, accounting was being introduced where it had not been before – across organisational boundaries; thirdly, fundholding and the accounting implication of the reforms was not compulsory – it was voluntary. With these three key features of general practice in mind, the introduction of fundholding needs to be set in some historical context of GPs because they have independent contractor status and it being voluntary. The significance is amplified because it appears that GPs, as patients' advocate for NHS resource consumption, had previously been left alone by successive accountable management reforms at least in terms of visibility and consequences across the practice boundary. Fundholding has more threads to it than other vehicles for NPM and as such the study in this new situation is justified because it will add to the literature on all of those counts, may have implications for accounting change and perhaps for accounting in motion and possible transformation of the organisation of general practice as part of the grander NHS.

Thus this next section places GPs in the contextual history of the NHS. It does not seek to present a full history of general practice but does present how GPs have fared

in order to set the scene and support the explication of the emerging empirical literature on the phenomenon of fundholding.

### **2.3 GPs and the NHS: A Short Contextual History**

The second aim of this chapter is to explore the GPs relationship to the NHS in order to set fundholding into a historic context. This section is an important element of the thesis because one cannot discuss primary-led care and resource management without considering the history of GPs within the NHS. Fundholding was based on choices for partners in general practice. It was a NPM reform but it was not explicitly forced on general practice and as such the decision to go fundholding relative to previous NHS reforms for GPs is an important element of the research.

The section demonstrates that since the birth of the NHS in 1948 the relationship of GPs to the NHS has been somewhat fraught and less straightforward than that of other members of the health service, for example, hospital doctors or nurses. The role and professional standing and the independence of GPs can be contrasted to the doctors in secondary care (hospitals). Why GPs are different to hospital doctors in the grand scheme of the NHS requires attention if we are to understand why the decision to go fundholding was so significant to general practice. Three key features of the institutional context of fundholding are deemed important considerations; GPs as independent contractors to the NHS; new accountability across the general practice boundary; and a voluntary scheme. This section sheds light on why GPs had a choice in this NPM reform, which was absent from other institutional contexts where it had been compulsory. More recently administrative structures have once again become available that enable GPs to commission services. This section will explain how the profession of general practice has been funded within the NHS prior to the first opportunity to commission care through fundholding. It will show how over time GPs have sought to retain professional status and autonomy throughout the various policy changes they have been subject to - through bargaining with the funding mechanism, and how in more recent times, to varying degrees, have become involved with resource management.

The reason fundholding was shaped the way it was lies deep in the history of the NHS (Glennister *et al.*, 1993). However, summaries of events that influence GPs prior to

1989 and the onset of fundholding are often confined to an introductory paragraph in the larger NHS literature. Basically, not much attention had been paid to GPs in the NHS reforms until fundholding. Successive governments had based reforms around secondary care until the creation of the internal market necessitated the purchaser/provider split. However, how the profession of general practice and the degree to which doctors engage in reforms is influenced by the previous attempts at reform and the profession's reaction to them. Through this section of the thesis, by reviewing how primary care evolved prior to fundholding, tracing the tumultuous journey of the GP through a wide range of NHS reforms, one can grasp why GPs have striven for and retained independent contractor status and why fundholding looked like it did. Therefore it is important to devote some time to revealing the history. It aims to set the scene to investigate the attempts at managing GPs as agents used to control the resources allocated to the NHS.

### **2.3.1 GPs: Before the NHS**

Table 2.2 is a constructed chronological representation of key milestones that contextualise the study up to the demise of fundholding. Prior to the creation of the National Health Service in 1948 the majority of the population in the UK were unable to access a health care system on a par with middle and upper classes that were catered for by local suburban hospitals. Access to a doctor was by payment. This raised inequalities in the access to health care in the UK. There was some improvement in the access to doctors through the 1911 National Insurance Bill when single-handed GPs could be seen by accessing a panel of doctors by the patient paying a 'stamp'. The Dawson Report (1920) advocated health centres as a good place to site GPs, rather than private places, giving a good central access point to doctors and other allied medical services. The government favoured health centres as a location for general practice.

### **2.3.2 GPs and the Creation of the NHS (1948)**

National Insurance Contributions, insuring contributors against sickness, evolved from the 1942 Beveridge report which introduced the notion of a National Health Service for everyone. The creation of a central fund for health services was accessible to all. The Beveridge report had been a focus for social security reforms but it had an inherent assumption 'B' (Webster, 1998) of an existing NHS.

<b>Document/Event</b>	<b>Year</b>	<b>Key Feature relative to GPs</b>
National Health Insurance 1911	1911	Voluntary Contributions to insure against sickness. GPs core role of certifying sickness rather than demand led patient care. GPs paid on a capitation basis.
Dawson Report	1920	Recommendation on administrative system. Suggested the creation of Health Centres.
White Paper A <i>National Health Service</i> ".	1944	Compulsory purchase of hospitals. Hospital consultants become salaried. GPs self-employed, contracted to NHS. Demand led culture for primary care. BMA reluctant.
Birth of NHS	1948	General Practice responsible for all personal medical services.
Capitation Basis	1951	Capitation funding is based on number of GPs and not number of patients.
Porrit	1962	Recommendations on administration. Criticised separation of hospitals, general practice and health authority.
GPs demand new contract and get one	1966	Contract changes demanded included better funding, including funding premises. Demanded more autonomy. Capitation based on number of patients, a practice allowance and fees for services.
BMA's GPs Charter	1965	Demanded right to provide good service ahead of demand for pay.
Cogwheel report	1967	Encouraged clinicians to get involved management.
Griffiths Report	1983	Introduction of general management at all levels of the NHS as a result of the Griffith's NHS Management Enquiry.
Working for Patients	1989	Purchaser/Provider split. Creation of internal market.
Income Generation Paper	1989	Department of Health issues guidelines on scope for income generation. Potential for entrepreneurship.
New GP Contract	1990	Linked more to performance. GPs "treated as independent contractors more in the sense of business entrepreneurs" (Lewis, 1997). Less of a 'gentleman's' agreement and more targets.
Fundholders	1991	First Fundholding GPs.
Revised New GP Contract	1994	GPs allowed to deliver more specialist services which had been the preserve of hospitals e.g. diabetes clinics in GP practices.
White Paper: Choice and Opportunity	1996	Introduced salaried option for GPs.
Management of District Health Authorities and Family Health Authorities joined together	April 1996	Move towards primary led care. Introduced the option of salaried GP.
White Paper	1997	Labour government elected and announces they will abolish GP fundholding.

**Table 2.2 Milestones for General Practice**

Although the Beveridge report introduced the NHS ideology it was left to Bevan to implement it. Central funding of the NHS implied central control of the medical profession as a whole with salaried staff working in centrally funded and specially

built environments. Salaried hospital consultants would be housed in hospitals and GPs were to be contracted to NHS and located in health centres. Importantly, particularly for GPs, the creation of healthcare for all abolished the possibility of lucrative private work at the ‘generalist level’ whilst consultants as specialist could still be paid privately if the demand was there.

Thus the concept of an NHS as one large administrative structure with limited resources, controlled by government involving free health care for all should have included access to GPs in health centres. Health centres became a focus of the NHS and were used as a way of controlling the distribution of GPs, controlled centrally by government to give parity of service. However, there were unintended consequences of the attempt to centralise health care control. GPs were resistant to a perceived loss of autonomy and were unhappy about losing private work (which was preserved for hospital consultants). Bevan became known as an ‘ally’ of the GP, being uncomfortable with a wholly centralised control mechanism for a NHS and an advocate of primary led care. Thus some of the divide between the employment status of being a hospital doctor and GP can be attributed to Bevan. Hence the 1944 White Paper, ‘A National Health Service’, set out to provide healthcare which was free at the point of delivery and funded by taxation. Even at this early stage of the development of a national health care system the primary health care providers had been vociferous about not being consulted enough, strengthened by an allergy to centralised control. They were “objecting to the administration and the lack of negotiation and consultation of the proposed Act with its subsequent effects on the livelihood of practitioners”, (BMA, 2005). From that professional resistance was born independent contractor status, albeit reporting to regional health boards. Independent contractor service gave GPs some freedom after losing the opportunity for private work but also set them free from being a salaried employee of the NHS.

The system that emerged was characterised by three tiers of control through different administration systems for hospitals, public health services and general practice. Such decentralisation did not force GPs into centrally administered health centres and therefore placated a profession resistant to centralised government control. This early battle for independence is important in the context of this study since professional autonomy versus state control has been a core feature of the relationship between GPs

and government, with a long history of resistance to change. This study of fundholding, a voluntary scheme, must be seen within that historical context of a medical profession resistant to change and where politicians in the past, in Bevan's own words, had 'stuffed the mouths of doctors with gold' (Allen, 1995).

### **2.3.3 GPs: Private Work and Funding**

Private hospitals, known as voluntary hospitals, underwent compulsory purchase and employees (doctors, nurses, porters etc.) became salaried NHS employees. GPs at that time were typically single-handed, self-employed practitioners serving their community by the award of a contract with the NHS. The GP became a supplier of services to the NHS. Over time the form and content of the contract, the conditions and monitoring mechanisms have been varied.

The nature of the contract and free access to GPs meant that GP services were determined by patient demand. Patients registered with a practice and made appointments freely, therefore demand was a function of accessibility, patient's choice and how informed a patient was. Cost was not a consideration. The NHS budget seemed limitless in the hands of patient demand - a demand led culture for NHS services in the primary care sector.

Although GPs achieved independent contractor status, hence autonomy, the relationship between primary care and secondary care doctors did result in a differential position for GPs relative to the hospital doctors in terms of prestige:

*"...it was no longer possible to combine hospital specialization and general practice; the high flyers took command of the hospital specialties, regarding general practice as the province of the failure... an ageing remnant left over... satisfied to play an ancillary role as 'gatekeepers'..."* (Webster, 1998, p.52).

Hospital doctors had a lucrative source of income providing services to voluntary hospitals, then part of the nationalized hospital scheme, where once they had provided services for free and subsidized by their private work. Moreover, the hospital doctors were allowed to continue with that private work in return for a reduction in salary which would have been more than doubly compensated for by private fees. The GPs,

not wishing to see their profession further diminished in prestige sought further demands on their administrative structure. As part of the separation from central control the GPs, through large representation on the BMA, had a steely determination to preserve professional autonomy, which was formidable enough to put at risk and possibly scupper the creation of a NHS. As a result of their demands the GPs gained further autonomy in other business affairs (Webster, 1989);

- (i) for goodwill being part of the sale/purchase of practices,
- (ii) payment solely by capitation under the GP contract
- (iii) abandonment of controls over the distribution of GPs and,
- (iv) ministers being the final source of appeal if a GP contract were to be terminated.

Later, these administrative structures were investigated in the Porritt Report (1962) which criticized the three tiers of administration and advocated a single tier. The report was a catalyst for a reorganization of the NHS (Webster, 1998) resulting in the remuneration of GPs by a peculiar capitation formula. The target income for a GP was multiplied by the number of GPs which then was the 'budget' that GPs could claim for under the capitation formula. The claims under the capitation system depended on the list size of the GP or partnership. Claims on the 'pool' were also reduced according to the amount of private work. This reduction was in direct contrast to hospital doctors who could enhance their NHS salary without condition with private work. Lewis (1998) performed a useful evaluation of the conflict between general practitioners and the state in the mid-1960s noting that the capitation worked favourably for GPs until the population increased dramatically through the 'baby boom'. Essentially the number of GPs relative to the population was decreasing and given how the large 'pool' was calculated the income of GPs was falling as funds were spread across a larger total capitation. The concentration of funds in the pool was being diluted by the expanding population as pounds per capita decreased. Meanwhile hospital doctors could still increase personal income through private work – the divide in status grew.

Consequently, GP esteem and morale was low in the mid-1960s which led to re-negotiation of the contract after the successful intervention with the GPs Charter (1965), authored by the BMA:

*The four principles of the Charter were the right to practise good medicine in up-to date, well-staffed accommodation; the right to practise medicine with the least possible intrusion by the state; the right to enjoy proper payment for the services rendered; and the right to financial security. The demand for the means to deliver a good service was thus put before pay. BMA Council members stressed that the Charter was as much a patients' as a doctors' Charter. (Lewis, 1998).*

Thus, GPs had to put 'service' to the patient at the forefront of their work while securing a better pay and reward system from a GP perspective.

#### **2.3.4 GPs in the 1980s: the Griffiths Report**

GPs have traditionally been independent contractors to the NHS with their professional and financial destiny tightly bound up in a contract. In terms of performance and service quality it was GPs that encouraged the quality of service to patients to be at the forefront of contract negotiations via the BMA Charter (1965). Butler (1993) reflected on four harbingers of the future of the NHS: the Griffiths Report (1983) which prescribed general management at all levels of the NHS; Department of Health (1989) guidelines on Income Generation that introduced entrepreneurialism into the equation; contracting out through competitive tendering in the NHS; the growth of internal markets derived from the purchaser/provider split. The Griffiths report also introduced customer influence which impacted on GPs through changes in the contract by linking targets to patients on the list size and also fundholding itself (Harrison and Pollitt, 1994). Linking health performance targets to list size increased the variability of practice income as less income was paid per practice and more per head of patient (tied up to contracts).

There were three main elements of the Griffiths recommendations: decentralization of responsibility; creation (1991) of self-governing NHS Trusts; and introduction of the purchaser/provider split. Griffiths (1983) introduced general management and alongside it words of 'efficiency' and 'quality'. General management posts would be

created forthwith at all levels, posts charged with accountability. Management units would hold budgets which would assist decision making enabling performance assessment and control (see Table 2.1) and accounting would enable organisational improvement in the NHS. For doctors in hospitals (clinicians) the process introduced clinical management budgets which:

*“... involve the assumption that (at least eventually) all clinicians will be willing to assume responsibility for expenditure on those resources whose volume they control, and also take an active interest in influencing costs and efficiency of use of indirect resources and overheads which they do not directly control,” (Perrin,1988).*

In a succession of reforms intended to cure the perceived ills of the UK's National Health Service (NHS), management has thus been the prescribed medicine, particularly since Griffiths promoted the introduction of a commercial business approach (Kelleher *et al.*, 1994). “Strengthening management, raising its profile and status, developing management skills and competencies, investing in management information systems and so on are seen as crucial to the success of policies directed towards securing value for money and improved quality of care for a given budget” (Hunter, 1994, p.2). These reforms included accounting a part of the process of management control for planning, decision making and performance management e.g. through targets.

### **2.3.5 Primary Led Care and Professional Autonomy**

From the 1990s onwards ‘a primary care-led NHS’ became pivotal and the GP was soon positioned at the forefront of NHS change. Liddell (1996) questioned what primary led care actually means and found three main attributes. Firstly, primary led care is about decision making and moving it as close to the patient as possible. Secondly, it is about the process of delivering and managing care with the ‘GP as Coordinator’ of the whole health care system as opposed to only managing the primary care team *in situ* – a common analogy was the GP as ‘gatekeeper’. Thirdly, he identified that it is about strengthened relationships. The GP was not just a feeder of referrals to secondary care but about being in the right location for care with the right local knowledge. Thus the GP was the agent of the patient and the hospital, an advocate for the patient in an informed and professional position.

Ham (1997) further emphasised the features of primary led care, emphasising the setting of general practice for a 'different' care service. There would be shared care between specialists and GPs of conditions such as diabetes; outpatient clinics in GP surgeries including GPs joining specialist clinics as professional development; diagnostic testing in the surgery; additional medical staff from chiropodists to physiotherapists. However, few studies of NHS reform had addressed the impact of the practice as more than just a setting for 'care' or paid attention to the actors in the social setting of the practice throughout these changes. The concept of the professional in these changing organisations has been considered. Harrison and Pollitt (1994) describe three notions of professionalism in welfare state organisations, in this instance, for doctors and their patient. They describe the notions as:

1. **Functionality of professional arrangements:** A patient places trust in the professional and two conditions must exist for that trust not to be exploited: firstly, the professional is free from outside interferences in exercising their judgment; and secondly, the profession must be largely self-regulating as only that profession has the technical capability.

2. **Occupational Control:** Professions and workers pursue 'occupational control', that is "more congenial conditions of work for themselves" (p.2) which may contradict the first notion as it is self-interest.

3. **The Illusion of Autonomy:** The contention that autonomy is partly an illusion because judgments are heavily influenced by the training and professions. Further, that an illness is an individual pathology and the GP takes away the visibility of rationality. Thus a GP faced with an illness brought on by lifestyle has operating autonomy but not full autonomy which may have been fostered through his/her training and therefore been socially created.

The April 1990 GP contract brought increased managerialism, accountability and control over GPs (Warwicker, 1998). Lewis (1997) described the 1966 contract as there to protect GP autonomy but that the 1990 contract began to treat GPs more as business entrepreneurs. The 1990 contract would give GPs a stronger hand in preventing illness in addition to treating it and because it was more business like the

debate began about the need for a management role for the general practitioner (Greenfield and Nayak, 1996). Family Health Service Authorities adopted a monitoring role with the advent of targets and were charged with inciting behavioural change among GPs (Laughlin *et al.*, 1994). Such changes had to be without harming the first of the three notions, that is, not harming the functionality of the professional arrangements of the GP (Harrison and Pollit, 1994). These targets were intended to encourage GP behaviour so that GPs assumed more responsibility for expenditure by early intervention with resources that they had control of, consequentially avoiding more expensive referrals. The targets did not include financial budgets but were clearly a form of performance management. Arguably the autonomy of GPs was being reduced as they were directed by targets and protocols that were much more detailed than under the previous contract.

It seems that the degree of occupational control and actual working arrangements were becoming less congenial. The new contract did add (Chambers & Belcher, 1993; Laughlin *et al.*, 1992, 1994) to the management burden, causing some resentment on the part of GPs who did not see the use of business and management methods as part of their professional role (Greenfield & Nayak, 1996). Some thought that the design of the new contract was without good scientific basis and was a way of increasing the workload of GPs (Warwicker, 1998). There was apparent resistance to impingement on professional autonomy with performance management. These contracts provide evidence of a move towards a more business like NHS using contracts but also early indications that GPs did not take a keen interest in their primary care led role of contributing to the management of the NHS, preferring to get on with their primary and autonomous professional role. Therefore why, later, would they volunteer for fundholding?

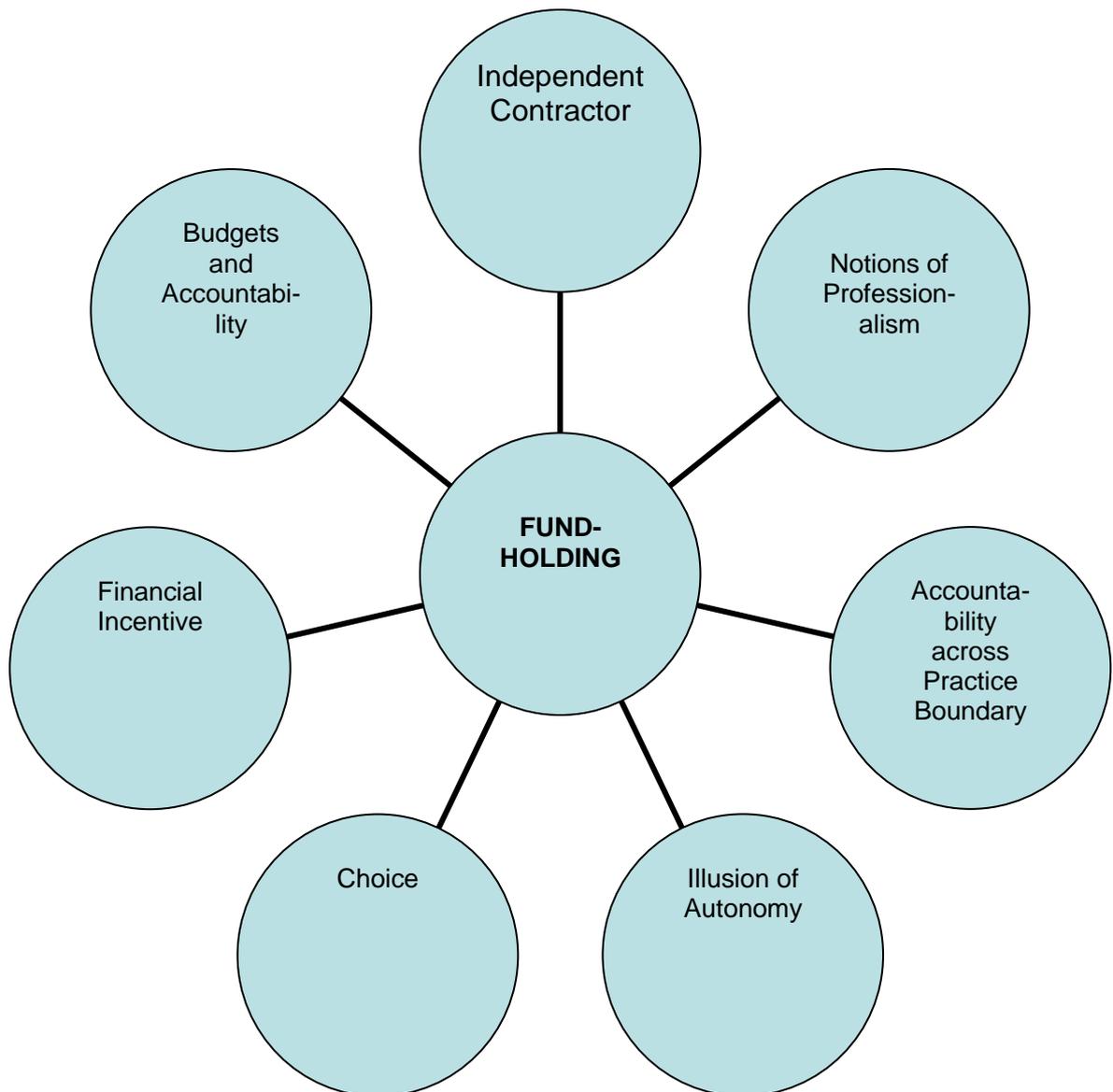
To encourage GPs to take on budgets a change in funding was sought to harness and direct GPs without harming perceived occupational control and retaining the illusion of autonomy. GPs were driving costs through decision making. Some costs might be reduced by delivery in the practice but GPs needed an incentive to be active in 'improved' primary led care. The solution was for funds to be allocated to general practice as a group of self-employed doctors outside the 'employed' boundary of the

NHS. However, with that allocation of funds came accountability and a need to encourage GPs to engage in the process, hence the allocation of budgets and the concepts of a profit, tactfully named ‘savings’ – fundholding was the proffered solution.

Figure 2.2 is constructed to show the factors thus far that have been discussed here as influencing the design of fundholding policy. NPM brought budgets and accountability. The historical context of the GP in relation to the NHS brought independent contractor status and notions of professionalism including the illusion of autonomy. GPs had fought to retain independent status (see Table 2.2) and if fundholding was to succeed then these elements needed to be retained. Bringing the principles of NPM and GP context together warranted accounting measurement and accountability across the practice boundary, hence budgets. Aligned with budgets the GPs were able to retain occupational control, part of the notion of professionalism, with the introduction of financial incentive – savings on budgets to spend on infrastructure. Choice was important since GPs were independent and historically resistant to central control then fundholding was voluntary and encouragement to go fundholding came with choice, the ability to be in control of purchasing from hospitals, hence shifting power away from consultants and financial incentive within the fundholding scheme.

Thus, Harrison and Pollitt’s (1994) notions of professionalism are reflected in the model in Figure 2.2; retaining functionality of professional arrangements as independent contractor; occupational control, for example, able to make use of financial incentives ; and, increasing the potential illusion of autonomy by shifting the balance of power away from the consultants.

This chapter so far has aimed to distinguish fundholding from other state organisations to which NPM applied by explaining what contributed to fundholding being designed the way it was. One of the features for fundholding was the GP entered it in a voluntary capacity, as an independent contractor rather than employee. Further, this section has introduced the notions of professionalism in order to set the flavour of the uniqueness of fundholding as part of the reforms, hand in hand with



**Figure 2.2 Factors Influencing the Design of Fundholding**

independent contractor status, accountability across boundaries and its voluntary nature.

Figure 2.2 summarises the factors discussed here that contributed to the design of fundholding in order to inform the research into why practices chose to go fundholding. Given that background why did the practice choose to go fundholding? What was the implication of accounting in the management of fundholding? Essentially, given the context of fundholding and the history of GPs relative to the

NHS there may be additional consequences of quantification by accounting in helping to construct organisational order as part of improvements in the management of the NHS. As a NPM ‘experiment’, in context, the consequences may be determined by the actors within fundholding.

## **2.4 Fundholding**

*Working for Patients* (1989) contained the first formal proposal for GPs to be given the choice to hold their own budgets with which to purchase a range of defined services, for example, outpatient treatment, elective surgery, diagnostic tests, investigations, drugs and appliances. The paper did not expressly comment on concerns about the demand led culture but argued that GPs were “uniquely placed to improve patients’ choice of good quality services” (section 2). The introduction of GP fundholding was a necessary part of the purchaser and provider split in the 1990s reforms and required each practice applying for the scheme to nominate a ‘lead partner’ for the initiative. Thus a decision to ‘go fundholding’ was simultaneously a commitment for a doctor in that practice to choose a lead role and, by implication possibly become more involved in accountability of the practice than other partners and possibly adopt a more managerial role. Alongside the changes for GP, some practices appointed fund managers or extended the roles of the practice manager to incorporate fundholding duties.

The first fundholders took responsibility for their budgets on 1 April 1990. The scheme expanded rapidly in a series of ‘waves’ with 2,200 funds serving almost half the population of England and Wales by 1995/96 (Audit Commission, 1996a). Over time the criteria of the list size for eligibility reduced and similarly, smaller practices that were ineligible alone formed multi- funds to enable participation in the scheme. Early indications were that funds following the patient under fundholding were being used to speed up the system, reducing waiting lists and paying private health care providers to treat NHS patients. All of these factors aimed towards a better patient /customer service.

Once a practice could demonstrate through list size and other criteria that they were capable of administering and managing fundholding then the practice was allocated a

budget for five main areas; in-patient care for selected operations; outpatient visits; diagnostic test as outpatients; drugs prescribed by the practice; practice staff (management allowance). Any savings in one area could be vired into another. Thus practices, headed by a lead GP, had to demonstrate fundholding management capability in order to duly receive a fund allocation and budget. The budget was core to fundholding and this can be concluded relative to the factors influencing the design of fundholding (Figure 2.2). Fundholding, via budgets, presented a structure which placed the GP at the heart of accountability with the strong incentive of financial savings, choice and power to influence purchasing in secondary care. All of this supported the retention of the notions of professionalism whilst apparently increasing power relative to hospital consultants whose service GPs were now purchasing.

The literature on fundholding predominantly concentrates on the *initial* impact of the NHS reforms, based in earlier waves, and how they were implemented (for example, Audit Commission, 1996a; Audit Commission, 1996b; Ellwood, 1996; Glennerster *et al.*, 1992; 1994). Thus, broad debates about NPM aside, - for example, about economic policy, accounting, measurement and management, in an attempt to create market efficiencies - it is clear that the accounting implications for fundholding as part of NPM were worthy of investigation as so little attention had been paid to it. A lot was said in the name of accounting under the broad mantle of NPM, and indeed hoped for, as budgets were devolved within public sector organisations in the name of organisational improvement. Pollitt (1993) described NPM as having four elements. Table 2.3 takes those four elements and illustrates them with the fundholding initiative.

The elements of NPM shown in Table 2.3 catapulted GPs into contract negotiation, budgets and monitoring of activity as a sacrifice for apparent autonomy in improving patient service. Thus on the one hand it can be seen as GPs taking power from the hospitals and on the other, it could be seen as the government exerting more power over GPs and the possibility that they would lose some of their independence and autonomy.

All of this, given the history of the GP as independent contractor, was contentious and inflammatory, *if* you were a GP but less so for the patient. Alongside decentralisation

and budget allocation this performance monitoring and setting of targets might be perceived as a form of control which further implies that the introduction of accounting of the scheme might be important and have some social impact for GPs, hence supporting the study. In terms of motivation to go fundholding the rhetoric of quality might be important, as advocates of the patient, purchasing services they could choose based on quality rather than only having one provider. However as the fourth element, consumerism, might encourage a more demanding customer, one might balance the other.

<b>Four Elements of NPM Pollitt (1993)</b>		<b>Application to Fundholding</b>
<b>Elements</b>	<b>Features</b>	
Quasi- markets	Bolder and large scale use of market-like mechanisms that could not be privatized.	The purchaser/provider split and allocation of budgets to GPs.
Decentralisation	Organisational and spatial decentralization of management and services	Allocation of budget to GPs. Creation of lead partner. Allocation of management allowances to practices. Ability to use savings to develop in house services.
Language of Quality	Rhetorical emphasis on need to improve service quality	Increased patient choice as services decentralized and GPs could purchase services beyond local provider. Implications of patient as 'customer' and GP as service provider.
Consumer	Relentless insistence that individual was the service user/consumer	Patient as customer with choice. Quasi-market itself. For example, patients no longer having to seek GP permission to 'move' practices.

**Table 2.3 NPM Applied to Fundholding**

Thus, it is argued that accounting was central to the quasi-markets structure and control over the elements caused by the decentralization of funds (See Table 2.3). A further layer of analysis explaining the application of NPM to fundholding can be combined with Hood's (1991; 1995) implications for accounting which were introduced earlier in the chapter.

The early part of the chapter has identified the broader issues of the NPM and considered GPs position to the NHS. This section has applied the NPM broad package (Pollitt, 1993) and Hood’s implications for accounting in order to explain fundholding (See Table 2.4). The next section identifies the literature on why practices went fundholding and the organisational impact of the reforms in the context of accounting for the reforms.

<b>Hood’s Implications for Accounting (1991;1995)</b>	<b>Fundholding Attribute</b>
More cost centre units. Clear identification of costs and understanding of cost structures and behaviours.	New and multiple cost centres within each budget allocated to each individual practice e.g. management allowance, diagnostic testing, drug budgets.
Cost data becoming increasingly commercially confidential.	Purchaser provider/split and contract negotiations within the internal market. Competition for contract and multiple suppliers. GP practices vying for the best price and services e.g. what to include in block contracts with providers.
Private sector accounting norms.	Introduction of budgets and ‘savings’ – mock term for profits.
Fewer general procedural constraints. More financial data for more management accountability.	Symbolized by cost centres, delegation of budgets as a whole.
More stress on bottom line	The ‘savings’.
Performance indicators and audit.	Fundholding practices were subject to individual audit by providers of funds – more scrutiny.
Blurring of funds for pay and activity.	Savings could be utilised for capital and/or patient care activity.

**Table 2.4 Assigning Hood’s NPM Implications for Accounting to Fundholding Attributes**

### **2.4.1 Going Fundholding: Early Studies**

The design of fundholding alongside notions of professionalism seem a recipe for encouraging GPs to go fundholding. One year after the start of fundholding there were two key studies published, Glennerster *et al.* (1992) and Glynn *et al.* (1992). Glennerster *et al.* (1992) had a broad remit on the introduction of fundholding and the impact of the NHS reforms and how they were implemented and found a number of weaknesses in fundholding making suggestions for improvement: the need for support for practices in poorer areas to join the scheme; safeguards to protect smaller practices

in the scheme and encouragement of sharing contracting and managerial skills; better administration and management support; increased accountability at practice level when monitoring value for money; the development of budgeting activities to increase flexibility and provide incentives about savings. They concluded that overall the first fundholders were a success and that the scheme should continue. The study implied that accounting and budgeting could be improved and hence the fundholding organisation could be improved, concurrent with accounting changing and improving the organisation.

On the other hand, Glynn *et al.* (1992) concentrated more on the accounting and noted misconceptions about what how comprehensive the services were that were covered by the budgets. Further, Glynn *et al.* (1992) noted that district health authorities and fundholders were developing ploys around budgeting to take advantage of the system yet concluded there was no evidence, despite rumour, that GPs might fund services with no direct patient benefit. They did conclude that if fundholding were to continue that there would need to be considerable development of “skills and managerial capabilities of the practices and it may be time for the new GP practice manager to come of age” (p.160). When going fundholding they observed that it was younger GPs taking lead partner roles, that none had sought external professional advice and reported only one instance where the lead partner and practice manager acted as a team.

Sometimes the practice manager took full control of fundholding and sometimes it was the lead partner. Glynn *et al.* (1992) were more concerned about the individual in fundholding and the way those actors were getting involved at practice level in contrast to the broader policy and level of NHS reforms in Glennerster *et al.*'s (1992) study. However, both of the studies from 1992 take a ‘reform’ view of fundholding using questionnaire and interviews based on a practice perspective. Both did provide insight into why practice chose to go fundholding and drew similar conclusions (see Table 2.5).

Both of the studies gave a brief mention to the imposition of the new accounting technology as part of fundholding and its role in fundholding. In the Glennerster study

<b>Glennerster <i>et al.</i>(1992)</b>	<b>Glynn <i>et al.</i> ( 1992)</b>
Desire to do something for patient care	Improvement in patient care
Referral freedom	Referral freedom
Service development	Better to be in at the start than join later
Budgetary freedom: savings and staff	Fairer allocation of resources
Independence and Control over their Professional lives	Improved financial management
Money and incentives	Better use of resources
Changing hospitals for patient good	

**Table 2.5 A Summary of Reasons for Going Fundholding**

there were suggestions accounting could be improved, implying it could contribute to fundholding, and in the Glynn study that there were indications of using accounting to improve financial management. These are both key indicators of accounting change for organisational improvement (Hopwood, 1987), and what accounting might do.

However, the treatment of accounting as part of the technology of fundholding in the studies was very superficial. Studies touched on the inadequacy of accounting and what it should and could be, therefore what it might create e.g. budgetary freedom and improved financial management. Although superficial, the studies were useful in beginning to understand why practices chose fundholding and that accounting was implicated and a factor in fundholding.

The studies were also useful in indicating who does what in the practice, which was further investigated by Newton *et al.* (1993) who noted that fundholders were given permission to fundhold based on ability to manage budgets but little prediction on how that would manifest itself in practice. The judgement to be able to manage was based on the administrative support and computer capacity for information systems. The ability to manage was founded on the assumption that technology and mechanisms could indicate the potential for management. However, Newton *et al.* (1993) further recognised that the reality of managing the budget hinged on those people in the practice and chose to concentrate on ‘roles’ within the practice. Newton *et al.* (1993) chose to study 10 first wave practices looking at the process of going fundholding and work roles: there was variability on the level of involvement of GPs, from practice managers being solely in charge to being mere ‘administrators’; GPs clinician role remained unchanged; GPs were influential in the decision to go

fundholding but then less involved in day-to-day tasks and contract negotiations. There were indications that some GPs were more involved than others. A practice wide analysis concluded that structure of authority within the practice remained unchanged, that there were few conflicts and tensions between partners and the profession and management domains and the “core professional had little involvement in the mechanics of the scheme”. This means that lead partners were seemingly not active in the accounting for the scheme as a mechanism. However, Newton *et al.* (1994) continued to emphasise the role of the practice manager, perhaps confusing with a fund manager role whereas many studies show they may not be one and the same. This may have arisen because they were early studies when fund manager roles had been less obvious or developed, and also the reliance on questionnaires which limit the examination of the reality of the situation. Further, by focusing on practice managers it can be argued that they are likely to be protective of their role and be less likely to acknowledge the involvement of GPs.

These early studies of fundholding revealed broad issues for early wave fundholders who chose fundholding for multiple reasons. The studies had also begun to consider accounting change and there were insights into the role of accounting and the roles of actors within the fundholding practice. However, some studies were more firmly situated in NPM, accountability and accountable management reforms and these will be considered in the next section of this chapter.

#### **2.4.2 Beginning to think about Fundholding and Accounting Change: Gaps in the Literature**

None of the three early studies considered the accounting technology of budgets in any depth and the implications of accounting in practice (Figure 2.1) nor did they consider the concept of being more business-like in general practice (Cowton and Drake, 2000). They did address why the practice went fundholding and some role implications for actors within existing general practice. There had been little attention paid to the context of accountable management within the GP fundholding practice and the impact of associated budgets in the research literature. This prompted the case studies in this study. As documented earlier in this chapter, prior to the start of fundholding in 1991, GPs had been subject to the 1990 GP contract and were under an apparent illusion of autonomy (Harrison and Pollitt, 1994). Laughlin *et al.* (1994)

observed that through the contract the government was seeking “to exert a new controlling influence over the behaviour of GPs, requiring them to perform certain defined tasks and opening them up to new forms of accountability aligned to these requirements,” (p.112). With fundholding it seems that what dare not be placed in the GP contract could be introduced via a voluntary scheme which designed in incentives (see Figure 2.2) and be part of accountable management reforms. Yet why would practices choose to go fundholding and choose to be accountable given the historic fight for autonomy (research question 1)?

Llewellyn and Grant (1996) did choose to focus on fundholding and its micro-impact on prescribing, consultations and referral and broader macro issues of resource management on six case study practices in Scotland. Whereas Newton *et al.* (1993; 1994) concentrated on the practice managers, Llewellyn and Grant (1996) took the view that the lead partner account of fundholding was key, as the head of a collective of fundholders with any one practice. The study skimmed the issue for resources management finding that GPs, holding budgets “perceive beneficial consequences for primary health care processes” (p.134). The study noted GPs’ ability to take on an enhanced management role, and they did so, without impact on their clinical practice time and were enthusiastic rather than resistant, delegating administration to other such as the practice manager. This enthusiasm for the management role was without precedent in the literature and there was some indication of differing degrees of enthusiasm in the published journal articles in this study (Cowton and Drake, 1999a, 1999b, 2000).

Thus far there was still little empirical attention being paid to why practices went fundholding and the accounting implications or the aspirations for a more business-like approach in the literature (Cowton and Drake, 2000). Ennew *et al.* (1998) had addressed that gap to some extent by examining the nature and characteristic of entrepreneurship demonstrated by fundholders. This approach is consistent with the introduction of the entrepreneurship theme as one of the milestone in general practice (Table 2.2). A more business-like approach for the NHS was reflected in the Income Generation Paper in 1989 which suggested scope for entrepreneurship. Ennew *et al.*’s (1998) study concluded that not all fundholding GPs wished to adopt an entrepreneurial role. There was some variety noted in enthusiasm and what GP

individual motivations were but there was no in depth analysis of why they went fundholding, possible accounting implications or who took lead roles and why.

The literature on fundholding was not extensive and there were gaps to be addressed. Firstly, the literature concentrated on early waves and how they were implemented. Secondly, despite accounting, budgets and accountability being the mechanism for fundholding, the accounting change did not feature in the literature. The lack of attention to the mechanism was surprising because it had been recognised and researched in other accountable management reforms. Further, recommendations to improve fundholding were often underpinned by the potential of accounting (Glennerster *et al.*, 1992). Thirdly, empirical studies focussed on practice management aspects and often the practice manager (Newton *et al.* 1993; 1994), largely ignoring GPs. There were further limitations to the understanding of fundholding by concentrating on the practice perspectives rather than the GPs themselves. The role of practice managers seems to meld with the fund manager and their views taken as fund managers but they were not always one and the same, particularly as fundholding became operational in the practice and fund managers were appointed. Fourthly, few studies investigated the practice reasons for going fundholding in the context of accountable management representing both a gap in the NPM literature and the lack of consideration of the accounting mechanism that underpinned fundholding. Thus there was a need for studies to consider and take account of the accountable management reforms from the perspective of the key players; the GPs and the fund manager, more so, when there were early indications of a management role for the lead partner.

The reasons for going fundholding had begun to be explored but often at a broad practice level; studies were few and there was scope to add to the numbers of studies. Despite the accounting change to general practice, surprisingly little attention had been paid to the mechanism and the actors. The implications of accounting were under explored but emerging as part of some of the reasons for going fundholding (Table 2.5). Fundholding was also studied by research evidence from the traditional players of general practice (GPs and practice managers) and hence the actors interviewed were part of the old general practice regime with no account of new roles and personnel. Consequently, little differentiation of the role of the fund manager was

evident nor was there focus on the fund manager as a separate role and function to the practice manager.

## **2.5 Conclusion**

NPM was applied across different public services. These ‘experiments’ have been observed by researchers, including, prior to this study, fundholding, to a small degree. Fundholding is clearly a child of NPM, and a prodigious one at that. It was an element of an attempt for broad organisational improvement of the NHS through the internal market. Integrating the contextual history of GPs to NHS enabled the reasons for the design of fundholding to become clear (summarised in Figure 2.2). Hood (1991, 1995) states that accounting had implications in practice but the lived experience may have a number of possibilities as suggested by Hopwood’s (1987) perspectives on accounting change. This sets the scene for phase one of the data collection and informs the design of the method to study the fundholding initiative.

Fundholding is a special case of NPM applied to the broader aspiration for the internal market in the NHS. It is underpinned by notions of accountability alongside notions of professionalism. When the two were merged the studies in other contexts focussed on the measurement of accounting for organisational improvement and did not consider the social aspects. The implications of accounting and any possible bearing in the management of fundholding had yet to be investigated.

The forthcoming chapters avoid the universalist approach, through an investigation of the why the practice chose to go fundholding and how accounting is implicated in the management of fundholding. It is evident that GPs have fought for their professional status as independent contractors yet volunteered for fundholding and accountability and that in itself warranted further investigation.

## Chapter 3

### Research Strategy

#### 3.1 Introduction

This chapter explains the research strategy for this thesis about fundholding. The strategy comprises two phases of data collection that are presented in three stages of analysis arising from a qualitative and inductive approach to the study of fundholding in 12 GP practices. It explains how the thesis adds to three published refereed papers by a second analysis of phase one data to contribute to a more recent developed literature which is presented here for the first time. In meeting that objective the researcher presents a confessional account; the researcher in a reflective position in time and social space (Bryman and Bell, 2011) and confessional through the ‘natural history’ of the project (Seale, 1999).

The research approach was essentially qualitative (Britten and Fisher, 1993). This chapter describes how the subject and research problem were ‘chosen’, the overall conduct of the research, research choices made and the time horizon (Saunders *et al.*, 2009), and reflections on the longitudinal nature and trustworthiness of the strategy. The study was initiated “with as few preconceptions as possible, relying on the accumulation of impressions which, with the aid of a facilitative human mind, eventually speak for themselves, so that new theories emerge from the real world,” (Seale, 1999, p.23). This longitudinal design involves taking a sample of GP practices (cases) in the first phase as the unit of analysis and GPs from within those practices in the second phase, consistent with a longitudinal design known as a panel study with data collected from the same people (Maddox, 1999; Bryman and Bell, 2007). A description of the data collection exercise for phase one is included in this chapter. The research journey begins with the research questions:

**RQ 1 Why did the practice choose to go fundholding?**

**RQ 2 How was accounting implicated in the management of fundholding?**

The data collection exercise for phase two and fieldwork is described in Chapter Seven as part of the inductive approach, as new understandings of the fundholding legacy emerge and further research questions emerge.

This section has introduced the chapter. The first section explains the qualitative nature of the study and confessional approach. The second section introduces the research time horizon and considers the trustworthiness (Lincoln and Guba, 1985) of the research. The third section provides some assumptions that inform the methodology. The fourth section explains the research choices: method; choice of sample practices and choice of questions. The fifth section explains the researcher as a bricoleur (Becker, 1988, cited in Denzin and Lincoln, 2005), a ‘quilt maker’, interpreting the data and the process of the emerging research questions.

### **3.2 Qualitative Research**

This section introduces the qualitative approach to the study. It does not enter the debate of explaining and validating the broad qualitative research approach, nor does it contrast it to the quantitative approach, since the qualitative approach is now a fundamental element of business research. However, a good place to start the chapter is in a definition of qualitative research:

*Qualitative research is a situated activity that locates the observer in the world. It consists of a set of material interpretive practices that make the world visible. These practices transform the world. It consists of a set of material interpretive practices that make the world into a series of representations, including field notes, interviews and conversations...an interpretive, naturalistic approach to the world...study things in their natural setting, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. (Denzin and Lincoln, 2005, p.3)*

Miles and Huberman (1994) comment that for qualitative researchers there are “few shared canons of how our studies should be reported” (p.299). The first phase and analysis of this study has already been reported in three published articles. Furthermore, there are contributions to be made as a part of the research journey of the researcher, through an inductive approach to present the legacy of fundholding. This qualitative study begins by making the practice of fundholding visible by interpreting why the practice chose to go fundholding and considering the

implications of accounting in the management of fundholding. As the research journey unfolds the interaction of the researcher with the world cannot be divorced from the study and its trajectory. The actors in fundholding cannot be divorced from that experience which means that not only is it an interpretation, presented as the work of the 'bricoleur' making sense of the data and the meanings people bring to them, but it is also a response to emergent questions.

Cowton (2000) suggests in his description of an emergent approach to research strategy, that the purpose is "to provide a reasoned justification for the conduct of the research" (p.76). This chapter explains the events and procedures that began with two research questions about fundholding. Why did practices go fundholding? How was accounting implicated in the management of fundholding, not simply for purposes of measurement, but in the application of fundholding in an organisation by key players? Key players are found to reveal more private accounts (Cornwell: 1984; 1988, cited in Seale, 1999) which brought about emergent research questions. Further, this account of the research strategy becomes confessional (Oakely, 1981) as it seeks to present a frank and honest description to capture why and how the phenomenon was studied. However, there is a challenge for the researcher in not being able to reveal too much of the findings from the first set of research questions too early. Thus, the thesis is not in a conventional format but does present the research journey through to the legacy of fundholding which is interpreted from accounts of those who lived the experience.

One of the key factors that impacted the research process was the demise of fundholding and the personal/professional/career changes for the researcher, albeit punctuated by successful publication of three refereed journal articles. Encouraged by Oakley's (1981) confessional approach, cited in Seale (1999), the art would be to identify further contributions of the fundholding research and justify unconventional reporting of the research experience for the thesis. By recognising the stops and starts that could have as much of a methodological and literature contribution as the anodyne accounts of methods – admitting to the choices and difficulties because it is a response to the emerging literature and the interaction of the researcher with the world. This is resonant of the qualitative researcher as the "bricoleur, or maker of quilts...deploying whatever strategies, methods and empirical materials are at hand" (Becker, 1988, p.2 cited in Denzin and Lincoln, 2005, p.5). Therefore from the

creation of the case studies, as the chapter progresses, the researcher admits to the twists and turns in the way the research developed. It is described as a process of analytic induction whereby causal links between observations in the data are synthesised to interpret and form an explanation and present new research questions. This account aims to give clarity and structure to the remainder of the thesis not as two separate studies of two data collection periods but as part of research journey in the collection of data, interpretation of data, its conceptualisation, formulation of new research questions and more data collection.

### **3.3 Research Time Horizon**

The aim in this section is for a holistic perspective to the research strategy, without revealing too much too soon of the interpretations and meaning emerging from the account, in order to explain the time horizon of the research. The timeline (figure 3.1) gives an audit trail to support the assessment of the trustworthiness and credibility of the research, leaving analysis and contributions for later chapters as one would find in a conventional thesis.

#### **3.3.1 The Timeline of the Study**

The timeline of the study shows the key events in general practice, and the data collection exercise, the research journey, including publications and the chapters in the thesis. It extends the milestones identified in Table 2.2 for general practice and situates the analysis of the phase one data, punctuated by publications. The publications contributed to the developing literature of doctors in management (indicated by shaded area in Figure 3.1 and reviewed in Chapter 5). This more developed literature of doctors in management, from 2000 onwards, presents emergent questions for the original data (Cowton and Drake, 1999a, 1999b, 2000), through the response to research questions 1 and 2. A literature review identifies what has been done, found and any gaps in the doctors in management literature (Chapter 5). In Chapter 6, the further analysis of the data from phase one interviews contributes to the doctors in management literature, specifically in primary care. Finally, phase two data collection concludes the study by examining how doctors' careers fare after fundholding.

EVENT	YEAR	RESEARCH	THESIS SECTION
Working for Patients: Birth of internal market and fundholding	1989		
Community Care Act introduces <b>fundholding</b>	1990		
First <b>fundholders</b>	1991		
Second wave	1992		
Third Wave	1993		
Fourth Wave	1994		
Fifth Wave	1995		
Sixth and final wave of <b>fundholding</b>	1996		
Labour government elected	1997	<b>Phase One data:</b> January 1997-January 1998	<b>Chapter 4:</b> phase one data findings and analysis: went fundholding and choosing the lead partner (published paper 2); emerging significance of the lead partner (published paper 1 – Taking the lead)
	1998		
Fundholding abolished (voluntary) and <b>PCGs</b> announced (compulsory)	1999	Published Paper No. 1 (Cowton and Drake, 1999a)	
		Published Paper No. 2 (Cowton and Drake, 1999b)	
	2000	Published (Cowton and Drake, 2000) Paper No. 3	
	2001		
	2002		
	2003		
	2004		
	2005		
	2006		
	2007	<b>INCREASE IN DOCTORS IN MANAGEMENT LITERATURE</b>	<b>Chapter 5:</b> literature
	2008		
	2009	<b>Phase Two data:</b> December 2008-March 2009	<b>Chapter 6:</b> phase one data findings and further analysis:
			<b>Chapter 7:</b> new data (phase two), findings and analysis
Conservative government elected GP Commissioning plans announced	2010		

**Figure 3.1 The timeline of the study**

### 3.3.2 Longitudinal Investigation and Trustworthiness

STAGE	COLLECTION TIME PERIOD	PRACTICES/ GPs
Phase One Interviews: Stage 1 Analysis	January 1997 – January 1998	12 Practices
Phase One Interviews: Stage 2 Analysis	January 1997 – January 1998	12 GPs
Phase Two Interviews	December 2008 – March 2009	6 GPs

**Table 3.1 Data Collection Periods**

The phase one interview data is historical (see Table 3.1) and has been published from but it has further value as a repository of data of a moment in the history of general practice. As a *bricoleur* the challenge in the thesis is to present a “collage or montage – a set of fluid, interconnected images and representations” (Denzin and Lincoln, 2005 p.5) to make sense of the data and make it valuable. It is true to say that at the time of phase one data collection the original research propositions were formed because of the regulatory framework (Burrell and Morgan, 1982) developing around fundholding. There were important questions about NPM experiments and for the researcher; there was the belief that there were implications of the role of accounting. The archive of interviews will be shown to transcend the time in which fundholding operated as a trusted source for further analysis of the implications of fundholding.

Fundholding ceased when it was inconsistent with the ‘new’ labour government who amended the regulatory framework. The research concluded with publications. Just as the change in government had consequences for GPs, changing the landscape of general practice, so did the researcher’s career change as new opportunities emerged in the management of higher education. Although the possibilities for GPs’ prospects of involvement in practice management of resources changed there were further developments in the doctors in management literature. As the literature grew it seemed that phase one data could further contribute to the emerging literature through additional analysis. Thus a further set of research questions and the collection of phase two data began in December 2008 (see Table 3.2).

The decade between the phases of data collection raised question about the quality of the research and the value of the contribution. The trustworthiness is important for the purpose of analysis, evaluation and recommendations. Denzin and Lincoln ( 2005), derived from Lincoln and Guba (1985) devised trustworthy criteria for qualitative research: credibility; transferability; dependability and confirmability. In extending the contribution of this study to make full use of the data “oriented to the contextual uniqueness” (Bryman and Bell, 2007, p.413). This thesis can contribute to the emergent literature and make a valid contribution according to the criteria in Table 3.2.

<b>Trustworthiness Criteria for Ascertaining the Quality of Qualitative Research</b> Source: Lincoln and Guba, 1985	<b>Parallels with Quantitative Research (Bryman and Bell, 2007, p. 411)</b>
<b>Credible:</b> Is the research believable?	Internal Validity: Causal relationship between two variables is sound
<b>Transferability:</b> Could it be applied in another context?	External Validity: Generalisability beyond specific research context
<b>Dependability:</b> Could it be applied at other times?	Reliability: Degree to which concept of organizing observations is stable
<b>Confirmability:</b> Did the researcher act in good faith?	Objectivity:

**Table 3.2 Comparing Traditional Measures with Trustworthiness**

Findings are credible because: the research is conducted with the GPs and fund managers who acted out fundholding rather than observers or proxies for those engaging in the phenomenon; they are enhanced by interpretation based on two sources of evidence (lead partner and fund manager); interviews are across 12 practice cases; and, in both phases the same GPs are interviewed. Transferability is achieved at a number of levels from both the method and findings: why organisations and individuals in the ‘public sector’ might *volunteer* to engage in NPM type initiatives, for example, in the current decade NHS trusts, schools and academies; to other professions that operate in partnership for example, lawyers and accountants and elect for a management role; relative to doctors in management going forward for example, across primary and secondary care (as considered in this thesis and an existing debate)

such as commissioning models of the current decade. The latter point also supports the dependability of the research – the issue of engaging doctors in management has not diminished and while that is a stable condition, the policies that present opportunities for engagement fluctuate with government. Did the researcher act in good faith? The researcher acted in good faith and the notion is supported by the confessional account. Therefore although the research is longitudinal it is trustworthy and the unconventional approach to the thesis helps support a trustworthy account.

### **3.4. Research Strategy**

The fourth section provides some assumptions that inform the methodology for investigating fundholding in GP practices. It presents the research strategy in more depth, addressing the ontological and epistemological perspective and the practical execution of the qualitative strategy.

#### **3.4.1 Ontological Perspective: Fundholding and GPs**

From an ontological perspective the research on volunteering for practice budgets is based in subjectivism, that the choices made for the practice and the shape of fundholding are not independent of the social actors, that is the GPs. Fundholding is viewed as being inseparable from those that volunteered for it and would not exist in its own right – it is not enforced.

The study aims to understand the reality of why the practice chose to go fundholding based on the interpretations of the interviews with GPs, with lead partner as proxy for the organisation hence subjective, but corroborated by interviews with the fund manager. This is of particular significance in considering the implications of accounting in fundholding at first hand with proximity to the actors. Accounting enabled the creation of a fundholding entity based on NPM propositions and adds complexities to the world of general practice. The choice for an organisation to be fundholding, made by a partnership, a group of individuals, means that a fundholding practice is not an objective entity. It can be measured as an objective entity e.g. list size, number of partners, practice demographics but it should not be evaluated along that criteria alone and in isolation it does not give fundholding a meaning or explanation. One can learn why the practice went fundholding based on the decision made by the partnership, made up of individual actors. In this study, the lead partner

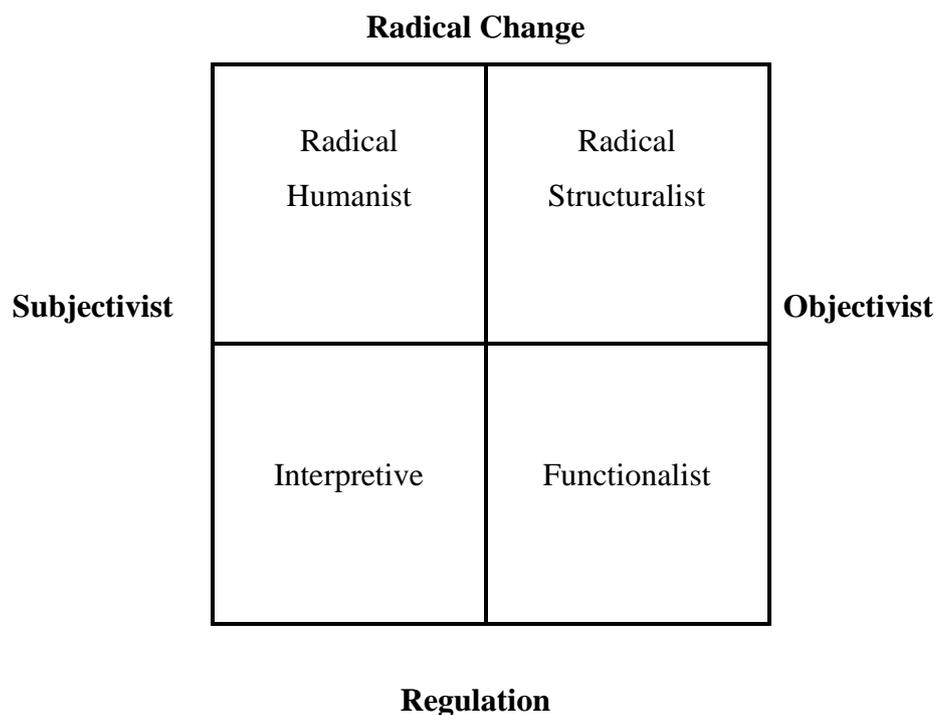
is assumed to be the spokesperson for that collective group of partners who choose to go fundholding and is interviewed as the 'lead' of that group. How the lead partner comes into the role may be an important consideration as a representation of the practice in going fundholding and as such is part of the interview (see Appendix A). The lead partner and fund manager together are the proxy for the practice in explicating why the practice went fundholding and the implications of accounting in the management of the fundholding process.

### **3.4.2 Epistemology: Interpretivism**

The way the knowledge is created in this thesis is through interpretation. General practice is an organisational structure that does not exist separately from the individuals who work within it thus the study interprets the views of GPs and fund manager acting out fundholding. GPs form practices and the practice collective may represent a diverse bunch of individuals constructing a social world of general practice. Therefore a researcher asking the question of why practices go fundholding is likely to discover a complex and subjective series of cases. The interview method based on a number of practices of differing sizes and differing waves will reflect some of the expected diversity of fundholding in the general practice 'world' to be studied. The interpretivist approach is in alignment with the important and complex background which GPs come into fundholding with (see chapter 2). Further it avoids assumptions and boundaries for accounting change as the actors reveal their own reality. A historical perspective of the independent contractor status in chapter 2 enabled sufficient exploration of the complex history of general practice to interpret the 'change' that volunteering fundholding brought about. The interviews enable examination of how the administrative and management structure of general practice might be affected in order to enable the researcher to address the research questions. This approach enables the motives of actors to be investigated. Both lead partner and the fund manager are expected to have a role and engagement with the accounting function as budgets are fundamental to fundholding.

In order to understand the approach to empirical research, Saunders *et al.* (2009) summarised Burrell and Morgans's (1982) four paradigms for the analysis of social theory (see Figure 3.1). In section 3.4.1 the subjectivist ontological position of this research study is explained by simplifying the assumptions under which a researcher

conducts their work. The Burrell and Morgan (1982) analysis is used here (see Figure 3.2) to allow explanation of the interpretivist approach and contrast it to the radical humanist paradigm as a comparative paradigm. This research does not have its roots in the radical humanist paradigm, which is also subjectivist, because it does not divorce actors from the social phenomenon. This research is not radical in that it does not concern itself with changing the status quo, that is, it does not concern itself with questioning fundholding in its potential to redress inequalities and injustice brought about by the reform. Such studies in the radical humanist paradigm would for example, examine the relationship between going fundholding and the variable of deprivation perhaps hypothesising that more practices go fundholding in order to redress inequalities in healthcare within a geographical location.



**Figure 3.2 Burrell and Morgans’s (1982) four paradigms for the analysis of social theory**

Therefore fundholding and the implication of accounting as a constituent part of its management of the phenomenon do have implications depending on the paradigm

selected by the researcher. Here the ontological position is subjective and it is acceptable to obtain knowledge from the situation held by practices in choosing to go fundholding, and the actor's motivations for doing so. The role of the researcher is to interpret the impact of fundholding rather than state cause and effect, this is particularly resonant given the context of GPs and why fundholding took the form it did. As GPs have been resistant to any change that reduced their autonomy by electing for fundholding they appear explicitly to do so, although any autonomy may be an illusion. Practices may chose fundholding to improve quality for their patients but that effect is not measured by this study. It does seek to investigate and explain why the practice chose to be fundholders. For example the aim is to provide explanation through sufficient conditions for going fundholding, using interviews and interpreting the subjective experience with the ultimate aim of having *more* cases, *more* interviews and *more* phases than other studies.

### **3.5 Research Strategy and Choices**

This section is concerned with research choices: choice of topic; choice of method; choice of sample practices, choice of questions. In the first instance the choices are consistent with the subjective nature of reality; choices and subsequent actions are those of the actors in leading and changing (if it does indeed change, and if so, to what degree) the practice to a fundholding practice. Hence, the study is not about precision and measurement such that it merits a quantitative approach. The research design needs to accommodate the decision to go fundholding and the role of accounting in the practice and management of fundholding thus; the method chosen to study fundholding would need to capture the response to deciding to go fundholding and the factors influencing the decision to 'go'. Thus , this section highlights the research questions and the method chosen by which to answer them much as Seale (1999) referred to Cornwell (1988) as being in three stages; firstly, learning about how the research problem was formulated; secondly, describing some choices and difficulties; and thirdly; some reflections on the analysis and interpretation of the data.

#### **3.5.1 The Evolution of the Subject Matter of the Thesis: Choice**

Part of the confessional account is that fundholding as the subject of research was first presented to the researcher, fresh to a first academic post, by a doctor in one of the

practices in the study. The researcher had taken an accountancy degree incorporating 'Accounting and Human Behaviour' (Hopwood, 1976) as a set text within the organisational behaviour module which became a favourite topic, later qualifying as a Chartered Accountant. The researcher began an academic career in 1992, appointed to a teaching post with the requirement to develop a research profile. A GP suggested that since their practice was going fundholding (third wave) they would welcome an accountant to share ideas with in the process of going and being fundholding, and that the relationship might be symbiotic. As a new academic employed to teach and research, and being more interested in the human and practical aspects and consequences of accounting than the technical, there was a possible fit between the proposed subject and the researcher. Thus a major factor in the decision to adopt fundholding as the subject of research was opportunity and access. Whilst fellow new academics were struggling for access and planning on the use of secondary data, it seemed that ease of access to primary and original data was a very good argument for pursuing the topic towards successful publication as an early career researcher. The combination of access to users of accounting in new territory in one of the most highly regarded professions, who were faced with significant organisational change, was a research topic with significant potential - thus the journey began.

### **3.5.2 Choice of Method**

Initially the researcher visited the practice on a regular basis to observe fundholding and how the accounting of the scheme was being implemented and developed. This involved discussion with a number of the GPs in the practice where upon it was quite clear that most had no interest in the fundholding activity itself; key players that were emerging were lead partner and fund manager. The researcher was allowed to move 'around' the practice freely discussing the scheme informally with GPs, nurses, practice manager, administrative staff. This familiarisation with fundholding included observation of the accounting of fundholding and the interaction of people with it. It became the starting point of the journey in order to design the strategy to investigate fundholding and how accounting was implicated in the management of it. The unit of analysis was the practice as it was the practice that went fundholding. The 'pilot' practice was the opportunity for access to fundholding practices (Practice A – third wave) and knowledge from that practice, through a number of visits and discussions

with GPs, practice manager, fund manager and consultants employed by the practice enabled the researcher to construct a strategy for execution of the research.

Other practices were recruited using a mixture of methods, some responded to an invitation and leaflet posted to fundholders on health authority lists with geographical proximity to the researcher. Others became involved as a result of recommendations or introductions from existing participants or some other ‘champion’ (Murphy *et al.*, 1992). This resulted in twelve practice case studies and a reasonable spread across different waves of fundholding and also different health authorities (see Table 3.3).

<b>Practice*</b>	<b>Wave</b>	<b>Health Authority</b>	<b>Approx. Patient List Size</b>	<b>No. of Partners</b>
A	3rd	W	10,000	6
B	3rd	X	11,500	8
D	3rd	W	12,400	7
E	1st	W	12,800	7
F	2nd	W	11,900	7
H	1st	Y	n/a	7
I	3rd	Z	8,000	5
J	1st	Y	n/a	6
L	4th	W	9,300	4
M	6th	Z	6,000	4
N	6th	Z	5,500	4
O	6th	Z	8,400	3

n/a = not available

\*Practices C, G and K are missing from the table because there is insufficient appropriate research material for them to be included.

**Table 3.3 Practices Participating in the Study**

The practices have been allocated letters (A to O) and the four Health Authorities have been allocated letters from the end of the alphabet (W to Z) to help maintain anonymity. Some of the elements of the practice profiles in Table 3.1 were collected by means of a pre-interview questionnaire (PIQ) which sought a number of pieces of factual information, including staffing, structure and list size.

### **3.5.2.1 The Pre-Interview Questionnaire (PIQ)**

Given the diversity in the way fundholding was practically implemented, largely due to the absence of any national or regional guidelines, the health authority information was limited to list size, lead GP, senior partner and wave. The primary purpose of the PIQ was to collect factual information, such as list size (Table 3.3) but its completion was also indicative of practice commitment to the study. Further, the PIQ was useful in the collation of basic information that was absent from publicly available information from the health authority. The PIQ helped to reduce the time pressure at interview hence allowed more scope for less structured questions and discussion at interview. It was also thought that the act of completing the PIQ might increase subjects' commitment to the interview-stage of the study, since they had already invested something in the project.

### **3.5.2.2 Choosing Method: the Semi-Structured Active Interview**

The chosen strategy to answer the research questions was the semi-structured interview to build individual general practice case studies. The instrumental people in fundholding were assumed to be the lead partner and the fund manager. Denzin (2001) summarised the interview as a way of “writing the world, a way of bringing the world into play: it is not a mirror of the external world; it is not a window on the inner life of the person; it is a miniature and coherent world in itself; it is an active text, where meaning is created and performed”. The phase one questions are located in Appendix 1. Although the interviews were much less structured than the PIQ, there was a skeleton of basic questions (see Appendix A) addressing issues such as:

- the process of deciding to go fundholding;
- choosing the lead partner;
- personal views of GP fundholding;
- the recruitment, employment background and role of the fund manager;
- general trends in the development of the practice pre- and post-fundholding;
- training and other individual development undertaken to implement fundholding;
- the production, availability and use of financial information;
- use of external advisers.

The interviews were recorded on a voice recorder and transcribed in full to “give insight into people’s subjective states” (Silverman, 2004, p.361). Further the method of interview technique used in this study can be described as ‘active’ (Holstein and Gubrium, 2004) where a standard set of questions are used to structure the interview but at necessary points, at the judgement of the interviewer, the interviewer chooses to ‘dig’. The approach enables the respondent to make a point clearer or is asked to expand an answer to give depth to the interview. This type of semi-structured interview was adopted because although there was a clear focus in the research questions 1 and 2, it allowed more specific emergent issues to be addressed (Bryman and Bell, 2007). There is flexibility and an opportunity for the interviewer to react and encourage the interviewee to elaborate on emergent points of the interview. Studies before had concentrated on the advances of NPM in the differing context of subject (economics, accounting , management) but little attention had been paid to the actors who were playing out these changes. As Pollitt (1993) recognized, “reforms did not merely alter lines on organisation charts: huge changes of role and skill were involved for those groups of staff concerned” (p.181). He asserted that many professionals in those new roles were not trained for them, nor did they relish them. This early observation for the impact on individuals involved in the reforms gives credence to the interview method, the ontological and interpretive stance, as it overcomes the direct questioning of questionnaires, with their closed and narrow questions.

The groups of questions sought, amongst other things, to contextualize the role of accounting through the views of the GP and the fund managers to see if it was important. The aim was to elucidate (see Appendix 1) the picture of fundholding and then explore why practices were going fundholding and the role of accounting (research questions 1 and 2) through interpretation and analysis. When designing the interviews there was a conscious decision not to constrain the format and content of questions. The aim of the interview was to outline with raised questions then ‘dig’ rather than steer the interview too much in order to allow the interviewee to embellish the point they wish to make. This approach was consistent with avoiding the creation of boundaries to the investigation of new the phenomenon.

This type of semi-structured interview conflicts with a more structured approach to interviewing where interaction is dismissed for the perceived belief that it will bias the interview evidence. In this instance, in such an under researched and little documented subject area, it was considered a necessity in order to reveal the individual experience of GPs in their lead partner roles during fundholding (and later career moves as a doctor involved in management) and fund manager. The active interview techniques is increasingly useful after phase one, when used in phase two, as it expresses the individual career trajectories of GPs which could not be anticipated. It captures and makes visible the transitions made in the GPs in their activity in management and careers post fundholding.

### **3.5.2.3 Selecting the Sample and Collecting the Data: Phase One**

The selection of practices was opportunistic and not random, but there is a reasonable spread across different 'waves' - three 1st, one 2nd, five 3rd, one 4th and three 6th<sup>2</sup>, suggesting that many relevant issues are likely to have been picked up from the interviews (Table 3.3). There was also a spread across four health authorities. The opportunistic and random approach enabled more cases and thus more interviews because both lead partner and fund manager were interviewed which was an advantage over studies that had examined fundholding before, for example, Newton *et al.*, (1993; 1994) and Llewellyn and Grant (1996). This contributed to one of the striking features of the findings, which was the range of experience and opinion found, in spite of the limited sample size. The research thus identified many points of significance, even if it is not possible to estimate how representative participants' views are of the wider population of fundholding practices or to claim that we have exhausted all possible issues and perspectives.

## **3.6 Interpreting the Data**

This fifth section explains the researcher as a bricoleur (Becker, 1988, cited in Denzin and Lincoln, 2005), a 'quilt maker', interpreting the data and the process of the

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<sup>2</sup> Beginning on 1st April 1991, the implementation of fundholding proceeded in a series of annual 'waves'. The first wave set a minimum patient list size for fundholding applicants of 9,000, but subsequent waves gradually reduced that requirement.

emerging research questions. A case study was constructed from each practice, based on the PIQ and interviews to present a vignette (research questions 1 and 2) of why the practice chose to go fundholding and the role of accounting in the management of the practice (presented in chapter four). The vignette tells the story from the interviews for each question in order to start to summarise emergent themes, similar to Doolin (2001).

### **3.6.1 Analytical Induction: Coping with Emergent Themes**

The multiple case studies are recorded and analysed in Chapter 4. The role of the case study of each practice, using the interviews, was to present a set of substantive cases for the purpose of interpretation of each practice going fundholding. Fundholding cannot have a reality beyond the social actors within it as it is born of choice by partners in the general practice that is eligible for fundholding at a point in time. However, one of the challenges for the qualitative researcher is deciding how to interpret and analyse the interview data. The researcher sought themes from the data with which to address the research questions. Seale (1999) states that “if a research account makes claims about the nature of the social realm that it seeks to describe or explain, then readers should expect to find evidence in support of these claims... Seeking for evidence within a fallibilistic framework that at no point claims ultimate truth, but regards claims as always subject to possible revision by new evidence, should be the central preoccupation for qualitative researchers...”, (p.52). Thus the qualitative researcher must be open to new evidence and is not seeking absolute truth. In seeking such evidence, qualitative researchers have tried various methods including triangulation, member validation, and analytic induction and searching for negative instances. These methods of seeking evidence are mentioned briefly here and have been reviewed in various method texts, for example see Bryman and Bell (2007), but also Seale (1999) for a comprehensive summary of various critiques.

The interviews were analysed through analytic induction (AI). The data were mined for evidence so that analysis will generate categories and labels for some conceptualization. Bryman and Bell (2007) define AI “as an approach to the analysis of data in which the researcher seeks universal explanations of phenomena by pursuing the collection of data until no cases that are inconsistent with a hypothetical explanation (deviant or negative cases) of a phenomenon are found”, (p.583). Seale

(1999) suggests that such a process of AI locates itself closely to a positivist ontology in order for rules and theory to be generated yet recognises that one does not have to subscribe to the positivistic ambitions in order to use AI to good effect:

*This is because it involves active seeking out of evidence to extend the scope and sophistication of theories.* (Seale, 1999, p. 86)

However, given the diversity experienced in the 12 practices the researcher can present evidence of sufficient multiple occurrences within the data to represent a condition/ theme. This promotes credibility without purporting to represent all the condition there might be were the whole population examined. While this research does not present hypotheses it does present interpreted themes. Thus the AI approach is not intended to be positivistic but is qualitative, used here as a framework for interpretive process, collecting data from, and thus analysing the interviews. It is useful to explain how qualitative interpretations are constructed from the data where the triangulation method, associated with seeking positive relationships and corroboration, does not seem suitable. Triangulation, relative to the method used, rather than seeking positivistic results, is the use of one method or source of data to study social phenomenon so that findings can be cross checked (Bryman and Bell, 2007). Triangulation therefore suggests a right or wrong answer rather than a scale and appears inconsistent with the way knowledge is emerging here, the subjectivist approach and assumptions about fundholding as constructed by the actors. Nor is seeking a right or wrong answer consistent with the diversity of the practices coming into fundholding and those selected in this study (see Table 3.1). Accounting for the methodology in this way also embraces the challenge in mining the phase one data for a second time and the researcher as *bricoleur* (Becker, 1988, p.2 cited in Denzin and Lincoln, 2005), to provide a sensical finding in the absence of a single interpretive truth. – taking the analogy further, no thesis using the same data would be the same. The analysis is used later to enable the collection of further personal (and hence private rather than organisational) accounts adding to those when the GP became active in the role of lead partner and the choices made in enacting that role.

To explicate this process, Table 3.4 documents Seale's (1999) five steps for analytic induction in the second column based on the positivist strategy. The third column

Step	Objective (Seale, 1999)	Practical Implementation
1	Roughly define the problem.	In the spirit of NPM GPs were able to volunteer to manage their own budgets with which to purchase secondary care. GPs were able to choose fundholding which presented a role for accounting and a new accountability. There were multiple reasons why practices chose to go fundholding. There are implications for accounting change.
2	Construct a hypothetical explanation i.e. a hypothesis.	That there would be implication of accounting in the management of fundholding. Accounting would be important and there would be observations that would explain the significance of accounting in that context.
3	Examine a case to see if it fits the hypothesis.	Twelve cases were examined. (Chapter 4: Going Fundholding – Practice Perspectives). Cases examined, knowledge extracted from the observations – construction of knowledge. Hypothetical explanation (stage 2) not confirmed. Emergence of unanticipated findings and patterns.
4	If the case does not fit, either reformulate the hypothesis, or redefine the problem to exclude the negative case. After a few cases a reasonable degree of certainty about the truth will have built up.	Reformulate the problem/question. Examine each case under new emergent findings (see Research questions 3 and 4). Inform reformulation with review of existing literature in the context of emergent findings (Chapter 5 – Doctors in Management).
5	Continue to search through several cases until negatives are no longer found. Some early theorist using AI suggest that a universal generalization will have been established.	<p><b>RQ 3 Why did they become the lead partner?</b></p> <p><b>RQ 4 How did they enact the management role; what did they do and how did they do it?</b></p>

**Table 3.4 Five steps of analytic induction adapted to obtain research evidence in this study for phase one data**

demonstrates the transition in this study through the steps in the second column; a subtle transformation of the AI steps from a positivistic towards a more subjectivist approach. Steps 1 and 2 reflect the creation of research questions 1 and 2, that is, where the research began. Step 3 demonstrates that the original hypothetical assumption, that accounting would be implicated in the management of fundholding, was proved not as important as anticipated. However, other new findings did emerge, research questions were formulated and evidence was collated.

In Step 4, the distinctive feature of the qualitative strategy here is that the interpretivist approach does not seek to eliminate negatives. The researcher creates new research questions (3 and 4) induced from the emergent findings in order to interpret and make sense of the visibility that the interviews have provided. Bryman and Bell (2011) comment that researchers analysing data as part of an inductive research strategy find it difficult to cope with emergent themes. The purpose of Table 3.2 is to explicate the iterative process in this study which seeks to resolve that difficulty and contain the risk of covering too many themes by isolating the emergent themes into new and specific research questions. The dilemma of too many emergent themes is also contained by the format of this non-conventional thesis in its challenge to use the archive of the original data and move forward from published contributions as part of the inductive approach. There were lots of ways in which fundholding could be investigated but this study sought to examine emergent rather than other themes, but may be informed by them. The findings from original questions inform the new questions and will inform the subsequent analysis of the new questions as themes and patterns emerge. However, it is not to say that universal trends are sought but rather there will be interpretations on factors that influence particular outcomes.

### **3.6.2 Conceptualising the Reasons for Being Lead Partner: Responding to an Emerging Research Question**

The emergent questions from an analysis of the phase one data necessitated a further interrogation of the interview data and subsequent analysis of the data to interpret emerging issues – in this instance:

#### **RQ 3 Why did the lead partner undertake that role?**

#### **RQ 4 How did the lead partner enact the management role; what did they do and how did they do it?**

The results of this second analysis of phase one are found in Chapter 6, informed by the literature review of doctors in management in the preceding chapter (Chapter 5).

### **3.7 Summary and Conclusion**

This chapter sets the scene for the remainder of the thesis. The timeline present the longitudinal nature and explains the research as trustworthy and contextually unique. The account of the research strategy identifies how the research problem was formulated as the result of taking an offer to examine fundholding in situ and the relationship of the researcher to the study and the timeline. The choices made reflect the difficulties of the exploratory study, the need for the selection of semi-structured interviews and the presentation of vignettes. These vignettes are then reflected upon as it is explained how emergent themes are incorporated into the research strategy.

The process of analytic induction explains and justifies how the emergent themes from the initial questions are contained as the study moves from the organisation of general practice and the unit of analysis becomes the lead partner. This is consistent with the qualitative paradigm responding to "...how events and patterns unfold over time" (p.412. Bryman and Bell, 2011). It is argued that the choice of the second analysis of phase one data was to complete the picture of the subjective experiences of the emergent key players of the research project, the GPs, providing new contribution presented in this thesis, beyond the publications. Moreover, later in this thesis, further contributions answer a third set of emergent research questions, to conclude the demise of fundholding, through recognising the legacy of fundholding for GPs who engaged in the management of it. That third and final phase (including the second stage of data collection) is reserved for the pen-ultimate chapter to the thesis, part of the inductive approach, as new understandings of the fundholding legacy emerge.

The value in this research strategy is the production of a study of fundholding that has more case of practices and more private accounts of key actors (lead partner and fund manager) than any published study of fundholding at that time. The research design facilitates a study that has more phases of study of fundholding than any known

study, certainly no study allows lead partners to reflect on their time as fundholders after experiencing other models for general practice, and as such presents the possibility to contribute on a number of levels beyond the era of fundholding – let the journey begin.

## Chapter 4

### Going Fundholding: Practice Perspectives

#### 4.1 Introduction

This chapter presents the cases and analysis for research questions one and two: why did the practice choose to go fundholding? How was accounting implicated in the management of fundholding? The analysis investigates why practices chose to go and the possible importance of accounting as a linchpin and embodiment of NPM reforms in general practice. Firstly a case study of each practice is presented describing: the nature of the practice; the reasons for going fundholding; the objectives that the practice seeks to achieve through fundholding status. Secondly, the role of accounting in the management of fundholding is analysed. Responses to both questions are taken from the lead partner and corroborated from the fund manager's perspective. This was the first incidence of a study of fundholding that focused on both the lead partner and fund manager and the findings were successfully published (Cowton and Drake, 1999a; 1999b), adding to the literature that focuses on practice perspectives (chapter 2). The forthcoming interpretations in this chapter include the findings that were published (Cowton and Drake, 1999a, 1999b, 2000) but further interpretations add to the publications and are presented here in the thesis for the first time. The aim is to acknowledge the potentially complex lived experience of going fundholding and avoid the one person-one practice view adopted by selecting only one person to represent the view of actors in the practice who take on fundholding. The cases presented here are based on phase one interviews (see Chapter 3) with lead partners and fund managers.

#### 4.2 The Practices

This section presents the case studies which are summaries of the PIQ and the interviews with the lead partner and fund manager. The practices are allocated a letter according to the order in which they engaged in the study thus Practice A was the first set of interviews.

#### **4.2.1 Practice A**

This third wave growing practice would have gone fundholding earlier but it was too small for the first wave and suffered partnership changes which scuppered going in the second wave. One partner in Practice A was vehemently anti-fundholding and the elected lead partner was originally against it too until he saw the potential. Fundholding was seen as a method by which the practice could be developed within NHS funding constraints. The computer allowance would allow the practice to develop its systems and there was perceived potential for budget savings to develop the practice's modern but cramped facilities. There was also a wish to protect the practice and its patients from a potential two-tier system and to take the practice patients' share of the fundholding financial 'pot', in spite of ethical concerns about fundholding on the part of the partners. There was a genuine belief that the scheme would support the practice ethos of looking after the patient interest:

*I think we thought that it was in our interests to look after our patients better... some people around who say that you should write the referral letter and then you should leave the system to deal with it...Some people never ever phone up about their patients and others do! (LP<sub>A</sub>)*

The partner who subsequently became the Lead Partner had been the first partner to suggest that the practice should go fundholding and had taken on board the paperwork involved in completing the process. Two other partners had expressed an interest in the role but withdrew at the meeting where the decision was made:

*...several partners were interested ... a specific partner had done a lot of groundwork and was very interested in it and put pressure on others for that partner to be allowed to continue as lead partner.(FM<sub>A</sub>)*

The Lead Partner recognised that he was a manager and seemed to enjoy the role. He enjoyed reading and thinking about what the practice should have been doing. He was active in fundholding in the HA in which his practice is located and prior to fundholding was active in health authority committees.

#### **4.2.2 Practice B**

This third wave practice was the first practice to go fundholding in a health authority with relatively few fundholders. Earlier attempts to be fundholders had failed because of in-partnership disagreement about whether they should participate in fundholding. According to the Practice Manager, who became the fund manager, the practice was

technologically advanced before fundholding and computerised, further because of his financial background, it had strong management systems. There was little financial incentive to go fundholding in order to improve those facets of the practice. The joint lead partner agreed that ‘much of the structure was already there and it was really just a case of employing people to do the donkey work to administer it, so management systems were in place already... no sudden need for management change... actually an administrative change’ (LP<sub>B</sub>). On that basis the ‘lead management partners’ became Lead Partners in fundholding by default.

The financially astute Practice Manager was interested in going fundholding but partners were wary as they had a collective view that some GPs were using fundholding for personal financial gain: ‘we thought that fundholders were essentially being bribed with management money to line their own pockets’ (LP<sub>B</sub>). The partners felt that the decision to go fundholding was, in effect, forced upon them. The Practice Manager commented:

*It became more urgent. Everything we tried to do with the Health Authority was blocked by, if you were fundholding, you could do this and that, and we've always been a fairly innovative practice.... Then as a bigger practice, we had 11,000 patients or so, we were up to do it, very few other people were, so we got all the pressure.... It was an urgent decision in the end.... We felt we'd got our arms up our backs, really...it just became impossible for us to do any development work and to pursue any of our interests in the provision of health without doing it. (LP<sub>B</sub>)*

Given this background, it is perhaps not surprising that the Lead Partner of Practice B was reluctant to take on the role, not least because he had ‘no idea how the money works in a practice at all, not a clue’ (LP<sub>B</sub>). However, the practice had already developed small management teams, prior to fundholding, where each partner headed a small group, for example in the area of staff or clinical protocols. The Lead Partner had worked jointly with another partner and the Practice Manager on technical development in the practice and they decided to take on the lead partner role together.

*...both of us reluctantly took it on – me particularly reluctantly. I had absolutely no desire to be involved in the commissioning of care and the negotiating of contracts and talking to consultants (LP<sub>B</sub>).*

However, although the practice was a reluctant recruit to fundholding, its subsequent experience proved to be much more positive than anticipated. The partners had not realised, initially, that fundholding could be a good ‘tool’: ‘we found our own way of

using fundholding for our purposes to try and influence provision of care in a broader sense' (LP<sub>B</sub>). They also thought it helped them regain some control after the advent of the new GP contract (Chambers and Belcher, 1993; Laughlin *et al.*, 1992, 1994).

Such was the enthusiasm that the practice became a Total Purchasing Pilot (TPP) practice, and the Lead Partner - an articulate man with strong, well thought-out views - now plays a much more significant part than he did at first. The way he regards his contribution is revealed in the following comment:

*I am more concerned with the strategy, rather than the mechanics, the management rather than the administration.*

#### **4.2.3 Practice D**

This third wave practice from HA<sub>W</sub> differed from Practice A (also HA<sub>W</sub>) as it was situated in dilapidated Health Authority premises whereas Practice A had a relatively new build. There had been a number of partnership changes in previous years. The senior partner who was renowned for his autocratic style had retired shortly after the current Lead Partner joined the practice. Prior to that retirement, 'partners all felt suppressed ... there was quite a lot of change ... became more democratic, tried to be more forward thinking ... up to and perhaps fundholding,' (LP<sub>D</sub>). There was a window for change but there was no distinct strategy in the reason for going fundholding; the Lead Partner described partners' views as 'ambivalent':

*The Practice felt as if it ought to go into fundholding rather than wanted to, that it would be the only opportunity to get updates on computerisation and access to advances in health care, and we also felt that we would get left behind if we didn't go in. (LP<sub>D</sub>)*

The fund manager was an external appointment after the decision to go fundholding and had perceived that there was a general feeling of a need to go fundholding because 'they had seen other practices in the area going third wave' (FM<sub>D</sub>).

Two partners volunteered for the lead partner role, including a new partner (interviewee) who had joined in the preparatory year and they worked together for a while. The new partner gradually took on increasing responsibility for fundholding as the scheme progressed. He saw himself, as least in part, as an 'entrepreneur' who was trying to organise good deals for the practice, both financially and clinically. Thus he

seemed to enjoy the activity associated with the role, which suited his energetic personality. He also saw himself as an ‘adviser’ to the partnership on the financial administrative aspects of fundholding. Further he viewed his role to a certain extent as a ‘policeman’, ensuring that fellow partners did not overspend or refer where they should not.

#### **4.2.4 Practice E**

Practice E (largest list size at almost 13,000) went fundholding in the first wave at the suggestion of the partner who became Lead Partner. Prior to fundholding the partnership had redeveloped three surgeries and extended another by using government initiatives such as the ‘cost-rent’ scheme for general practices. The practice was not averse to tapping in to government funding schemes to develop the organization. It seemed that fundholding would enable developments beyond partnership infrastructure, through computerization and increased human resource. Prior to fundholding it was neither computerized nor was employing a practice manager and on that basis was originally refused fundholding status. The practice acquired sufficient funding to improve the computer systems which then allowed the fundholding application to succeed.

A particular feature of this fundholding practice was the personality and influence of the Lead Partner who took that role as no other partner in the practice wished to take it. A ‘larger-than-life’ figure with enormous enthusiasm for innovation and practice development, he saw fundholding as ‘an opportunity that we didn’t know we wanted, but having seen what it could offer, gave us the opportunity to do most of the things that we wanted to do with General Practice’. However, he was faced with fellow partners who were lukewarm about fundholding and required much persuasion and bargaining.

*They finally agreed when it was decided that I would do all the work, and as long as it didn’t interfere with them, we could go fundholding. (LP<sub>E</sub>)*

He saw himself as a ‘motivator, an innovator and perpetrator’ and admitted that adopting the Lead Partner role had relieved him of the boredom of general practice.

#### 4.2.5 Practice F<sup>3</sup>

Initially this second wave practice would have joined the first wave of fundholders but, having followed the preparatory procedures for that year, the partners decided against due to the practice's lack of computerisation and poor management structure. Thus after two preparatory years the practice succeeded in going fundholding, despite the Fund Manager - who is also the Practice Manager - describing the partners, including the original Lead Partner, as 'reluctant fundholders'. According to the fund manager, the single reason for going fundholding was to protect the local hospital which was under serious threat of closure. The Fund Manager stated that the practice has not obtained as much patient benefit from fundholding as other practices, primarily because much of the contracting was to be directed at the local hospital rather than from a selection of secondary care providers.

Finding a lead partner was not easy:

*I'd like to say that there were volunteers, but I think it was more or less volunteered by other people saying they didn't want to do it. The senior partner said he would do it and one of the junior partners agreed to do it with him, so we've always had two and that's more or less how it was agreed initially, by default rather than enthusiasm. (FM<sub>F</sub>)*

The Lead Partner changed after two years, ostensibly to enable different people to experience the role (FM<sub>F</sub>). However, in this practice, it was clear that much of the responsibility that came with fundholding was carried by the Fund Manager. The Fund Manger had a strong NHS background, including at executive level. In the absence of an interview from the Lead Partner it is difficult to say whether this significant role assumed by the fund manager was a product of the practice stance on fundholding i.e. he was appointed into that role to meet the partners' expectations of fundholding, keeping it away from the professional doctor role. It may have been that, quite simply, because the Fund Manager was from an NHS management background with strong negotiating skills for secondary care contracts, that once in place no one GP saw reason for a significant Lead Partner role. However, the interview data hints at the former, that is, he was appointed to minimize the impact of fundholding on the

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<sup>3</sup> It was not possible to interview the Lead Partner, but the PIQ and fund/practice manager's interview had been completed and provide some useful insights to warrant inclusion of Practice E in phase one data. The difficulty of gaining access to the Lead Partner also said something about how the practice is run.

doctors in the practice enabling GPs to attend to their ‘day job’ without engaging in the politics and administration of the particular health authority antics:

*... one of the things they wanted me to do was to sort of look into the fundholding for them... it all boiled down to one thing in the end...purely to try and do the best we could for WG hospital because it was under threat of closure (FM<sub>F</sub>)*

#### **4.2.6 Practice H**

This first wave practice went fundholding under the auspices of the now retired senior partner but without unanimous support. It was approached by the Health Authority to go fundholding which was taken to partnership vote with a majority in favour but with one partner dissenting. Even those partners who voted for fundholding did not seem to have been particularly positive about it:

*We knew it was something the government was going to pursue ardently. If we were going to get anything out of it, the goodies were going to come in the first few years. (LP<sup>H</sup>)*

Their approach appeared to have been partly tactical, believing that the government would be offering incentives in the early years and that the alternatives for them were worse. However, at that time, there was also a sense in which applying for fundholding status at an early stage fitted with its more general profile as a training practice and was consistent with the practice as an innovator:

*The main reason was that, they were not always positive reasons, it was the fact that, it wasn't that they wanted to be fundholding...it's that the alternatives were worse... they were one of the practices that would do things first (FM<sub>J</sub>)*

A further reason for joining was to improve the levels of management throughout the practice.

*..improve patient care, there was a desperate need to improve management at all levels. (LP<sup>H</sup>)*

The senior partner, retired at time of practice interviews, had originally suggested that the practice should go fundholding after approach by the Health Authority (as in Practice D). The Lead Partner joined the practice just prior to the decision to go fundholding and acted as understudy to the senior partner. The Lead Partner had, by his own admission, a leaning towards the business side, possibly because of his

family's commercial background, and he had already adopted tasks such as monitoring prescribing practice. His manner was business-like and he had a command of detail. Yet he also has strong views about the larger picture of NHS management, which he would like to see undergo significant change - 'like my views or not, I'm sticking to them'. This seems to have been a motivating factor in his adoption of the Lead Partner role.

#### **4.2.7 Practice I**

The partners of this practice originally considered applying for fundholding status at the inception of the scheme, but it was concluded that a 'wait and see' approach was appropriate in order to evaluate developments, particularly in the light of the impending 1992 General Election. The practice went fundholding as part of the third wave mainly because of the opportunity to influence health care, although all the partners except the Lead Partner were sceptical about the scheme's potential. The Fund Manager describing the partners views as 'totally ambivalent':

*GPs that were anti-fundholding didn't want to see it making any difference to the way they had to work ... the NHS is about people, it's not about business or finance to a great degree apart from the fact that a financial number has been allocated to XYZ operations. (FM<sub>1</sub>)*

Both Lead Partner and Fund Manager referred to the departure of a practice general manager who left for 'various reasons'. It was intimated that the general manager left after being somewhat frustrated and thwarted in embedding the financial aspects of fundholding into the culture of the practice. On his departure the Fund Manager interviewed was promoted into that role from the IT role in the practice where he reported to the departed general manager.

*The opinion was not one of being reluctant fundholders but rather being sceptical fundholders and going in, I suppose, for the perceived benefits without genuinely believing that it was the right way to go. (LP<sub>1</sub>)*

The Lead Partner adopted the role because there was no competition from any of the other partners in the practice.

*I'd always had an interest in the business side of the practice anyway and as this was seen as being mainly a business venture, it fell to me and nobody else was particularly interested in challenging that. (LP<sub>1</sub>)*

#### 4.2.8 Practice J

The decision for this practice to go fundholding was inseparable from the Lead Partner's active external role in fundholding. The partner, who had strong views about things such as information technology and rationing in the NHS, was a member of the fundholding management advisory group and active in the NHS region in setting up the fundholding initiative. The suggestion that the practice should be fundholding was born at the same time as the fundholding concept, before any of the mechanics of the scheme were announced and the Lead Partner even wrote his own fundholding software.

Although the Lead Partner emphasised that the decision to go fundholding was a democratic one, the Fund Manager pointed out that some of the partners were still 'ardent anti-fundholders', but that 'one or two strong partners ... can push things through the other partners'.

*He felt, that the practice felt, particularly he felt, he pushed it through the practice as I'm aware. He felt that the health authority had not performed well in the past...it was not for savings...they thought they could purchase better for their patients than anybody else. (FM<sub>J</sub>)*

It was assumed that the Lead Partner would undertake the role because of his support for fundholding and his knowledge of the scheme, developed in his capacity as adviser to the Health Authority.

The dominant influence of the Lead Partner does not mean that the practice went fundholding for that individual's own selfish reasons for at the heart of the decision was the objective of taking advantage of the early benefits of the scheme based on wisdom, having experienced a sequence of Department of Health policies:

*Because we felt that if we didn't get in at the start we wouldn't get the benefits, things would have whittled down by the time we got through. We're quite used to the government, the health department, changing things as they go along, moving the goalposts. So thought if we got in at the ground we would be able to make a change and move with a change of our own accord rather than be changed against our will. (LP<sub>J</sub>)*

Additionally, as the latter part of the above extract shows there some element of striving for independence rather than being dictated to by the government albeit within the context of a government initiative.

#### **4.2.9 Practice L**

Practice L was the last one to go fundholding in their health authority area. The fundholding scheme was a way for the practice to fulfil the desire to develop in-house services. The Fund Manager acknowledged that the partners ‘felt they were in a position to be able to do some development on the practice’ which it did, with the creation of a minor operating suite and various in-house clinics. Moreover, as a result of the local hospital pointing out to patients the potential for speedier treatment of fundholding patients, the decision was sealed for the partners in practice L. The partners did not wish their patients to be at a disadvantage compared to local practices. (The local hospital is the same as that for Practice F, which had gone fundholding to help keep it open.) However, to go fundholding the practice did have to join forces with another practice, outside the immediate vicinity, to meet the minimum list size criterion. That practice also happened to be the single-handed GP practice owned by LP<sub>L</sub>’s wife.

Support for fundholding had originated with the senior partner, but his colleagues were ‘sceptical’ about the whole idea. The senior partner subsequently took on the role of Lead Partner:

*The idea was entirely mine. It originated with me...The others did not have much enthusiasm and the practice we joined up with is a single handed practice so the ball was left with me to start playing with it as I wanted. (LP<sub>L</sub>)*

Thus he had, at least to some extent, been able to pursue his own agenda, and he had taken satisfaction from the ability to influence the provision of services.

#### **4.2.10 Practice M**

This sixth wave practice operates from health authority-owned premises shared with Practice N in a deprived area. Sharing of premises gave impetus to practice M going fundholding alongside practice N. Both practices became eligible due to the criterion for the minimum list size being reduced;

*Our practice did not want to go fundholding because at the time we had ethical objections because we didn't see it was a fair system.... The other practice in this building announced they were going fundholding sixth wave. We were given three days to make up our minds whether we were going or not. So we felt it would be absolutely impossible in a building where we share staff and management for one to go fundholding and one not to. (LP<sub>M</sub>)*

Under these circumstances the practice saw a non-fundholding practice as untenable and became accidental fundholders. The Fund Manger pointed out that, 'they didn't actually think of it'. Essentially this practice was an accidental fundholder without strategic practice motivation to be fundholders.

However, overall the Lead Partner took 'a completely different view' of fundholding, because she had found that 'being in control of your own budget and your own destiny gives you an awful lot of power' to deal with problems that arise in relation to the provision of secondary care. She therefore feels that instead of taking the 'moral high ground':

*Perhaps if I'd gone and seen what you can do with fundholding and the things you can bring in, the services you can attract, perhaps I would have persuaded my partners to have gone sooner and ... we could have made huge savings ... and we could have been out of this place [premises] a lot sooner than we're going to be. (LP<sub>M</sub>)*

The Lead Partner felt that there was little choice but for her to take on the role, for the other two partners were not interested:

*I've got two male partners who are just not interested in any way, shape or form in management, money, that type of budgeting, or going to meetings. So basically I decided if we wanted to do it properly that I would have to do it. So I took it on. (LP<sub>M</sub>)*

Although she had enjoyed developing practice services, she did not really see herself as a manager but rather a doctor who had picked up certain skills.

#### **4.2.11 Practice N**

The Lead Partner decided that the practice, which shared health authority premises with practice M, should go fundholding as soon as it was eligible under the reduced list size criterion which applied for the sixth wave, that is, a list size drop to 5,000:

*He didn't tell anyone until almost the eleventh hour. Both [M and N] went sixth wave. There was quite a big push from the Health Authority to get as many people as possible ... managers in the Health Authority trying to persuade practices. (FM<sub>LM+N</sub>)*

One partner was 'dead against it', but the Lead Partner was supported by two other partners. The reason for going fundholding was explicit, having monitored the expansion of fundholding as the scheme was opened up to smaller practices, it was about seizing the opportunity as soon as the list size criterion was reduced. The practice itself was constrained by its size before fundholding from delivering the patient services desired by its partners. Fundholding gave the practice the money to develop further services so that the small practice could develop in terms of patient services through delivering a number of outreach clinics on the practice premises and other in-house services (e.g. minor surgery, chiropody, physiotherapy etc.).

The Lead Partner claimed that he was 'conned' into taking on the role, but the Fund Manager believes that the partner's personality is such that he prefers to be in control, which is consistent with his account of the decision to go fundholding.

#### **4.2.12 Practice O**

This practice, with some coercion from the Health Authority, chose to go fundholding at the sixth wave in order to develop facilities and services in recently refurbished partner-owned premises:

*It was really the FHSA - came round and twisted our arm and then we decided that while all the other bigger practices in the area were going fundholding then we ought to...None of the partners were totally against fundholding, I suppose there was no opinion really. I think if it had to be it had to be. (LP<sub>O</sub>)*

Thus, none of the partners was totally against fundholding, but there was a sense of inevitability about it. The practice was developing quickly having moved from 'grotty premises' and was expanding in-house services such as counselling and physiotherapy to new areas such as cryo-surgery.

The Lead Partner volunteered for the role but had few strong views about it - or kept them to himself.

### **4.3 Going Fundholding: Practice Overview and Analysis**

This section identifies major factors for the practice in going fundholding. The Lead Partner and Fund Manager in each case articulated at varying length their reasons, from both the practice, their own and the lead partner perspectives, for participating in fundholding. Their comments are summarized with an increasing level of depth of analysis through Table 4.1, 4.2 and 4.3.

The decision to go fundholding was implicitly about a partnership taking on the management of a budget that was financially incentivised by a management allowance and the potential to make, and retain, a saving on the budget. GPs chose to do this within the notion of professionalism (Harrison and Pollitt, 1994). The patient places trust in them and taking on board such financial accountability would not cause such trust to be exploited but would help in the allocation of NHS resources. GPs remained self-regulated and exercised professional medical judgment. However, given the contextual history of GPs within the NHS, striving for the retention of independent contractor status and professional autonomy, there are question about why they chose to be fundholding and hence be accountable across the practice boundary through the mechanism of budgets. The following section aims to capture the reasons for going fundholding and the back ground to becoming the lead partner, integrating the literature on fundholding although it was confined to studies of the earlier waves.

The partnership was the contracting body that went fundholding. However, studies such Llewellyn and Grant (1996), Cowton and Drake (1999a; 1999b) concentrated on the lead partner despite also interviewing the practice manager. Further, they assumed that the GP is “the person taking fundholding forward...most active in developing fundholding and in articulating its aims and achievements”, (p.126). They did not evaluate fundholding in the context of the views of any other players than the GP, as a key player driving the fundholding vehicle. Thus one of the contributions to the

trustworthiness of the research is the corroboration of the data from more than one source.

#### **4.3.1 Who Went Fundholding and Dominant Reason for Going Fundholding**

The dominant reason for each practice going fundholding is summarised in Table 4.1 and is the simplest level of analysis of the data. Moreover, in contrast to published studies such as Llewellyn and Grant (1996) and Cowton and Drake (1999a; 1999b) it emphasises both the Lead Partner and Fund Manager interviews in order to obtain and corroborate data from both sources. This provides a larger and clearer window with which to view the collective decision of the partnership (Table 4.1). The case studies of the practices do not reveal a single common principal reason for going fundholding, rather a variety of reasons. This simple analysis is a starting point to set the scene for a deeper analysis that was lacking in other studies.

<b>Practice</b>	<b>Principal Reason</b>
<b>A</b>	Develop and improve the practice
<b>B</b>	Actively seeking financial gains from the scheme
<b>D</b>	Avoid being left behind
<b>E</b>	Actively seeking financial gains for practice development
<b>F</b>	Protect the local hospital
<b>H</b>	Encouragement by health authority
<b>I</b>	Influence health care
<b>J</b>	Domination of Lead Partners' desire to be a fundholder
<b>L</b>	Develop in-house services
<b>M</b>	Accidentally by virtue of shared premises with another practice
<b>N</b>	Develop further services
<b>O</b>	Encouragement by Health Authority

**Table 4.1 Principal Reasons for the Practice Going Fundholding**

There is, as one might expect, similarity and variety in the reasons for participating in a voluntary arrangement. There is some degree of commonality in the motives for

going fundholding and most address some need or needs of the key stakeholders: practice; patients; partner (s); health authority. Some of the principal reasons may be viewed as more positive for the practice, hence partnership, itself such as developing in-house services. Other principal reasons are more positively focused for patients such as preserving the local hospital. There is also a case of individual Lead Partner's reason in the personal desire to be fundholders indicating that fundholding might proffer more congenial conditions for the partner concerned, reflecting more self interest in terms of occupational control as defined by Harrison and Pollitt (1994). However, not too much can be inferred from these principal reasons as they are not mutually exclusive and what may be positive for one stakeholder may be viewed as negative for another. Therefore there is a need to investigate the complexity behind the apparent dominant reason for going fundholding (see 4.3.3).

Before progressing the analysis it is useful to compare the principal reasons for going fundholding (Table 4.1) with the literature that also identified principal reasons. This study adds to that literature, see Glennerster *et al.* (1992) and Glynn *et al.* (1992) shown in Table 2.5 by revealing reasons beyond those previously disclosed in the literature: some practice went fundholding because of a dominant lead partner (Practice J); and, one practice went accidentally because of shared infrastructure (Practice M). These principal reasons (Table 4.1) are also less generic than those described in Table 2.5 perhaps because this study had case studies from five of the six waves rather than just the early waves. Nonetheless, these findings add to the diversity and complexity of the principal reasons for going fundholding. Generalising provides a good summary to compare with the literature but it does discount some of the variety. It is important to explore the richness in this variety. Dominant reasons may also be vague such as 'influencing health care' and other reasons are defensive, for example, avoiding being left behind and protecting the local hospital. Moreover, the early analysis suggests that not all reasons for going fundholding could be presented in an attractive and positive light which suggest that choice and preference for going fundholding may be an aversion for the alternative rather than a predilection for fundholding itself.

Thus far, though general practice was empowered with the choice of fundholding this early part of the study shows it was not always viewed as an overall positive opportunity. In Table 4.1, Practice A, for example, is described as going fundholding with an overall view to developing and improving the practice, a broad description and beneficial to all stakeholders. For some, developing and improving the practice is more defined by a particular route such as Practice L seeking in-house service improvement, or Practice E focusing on financial gains to develop the practice organisationally, through increased management and human resource. This expands on Llewellyn and Grant (1996) who identified the broader incentive of ‘savings’. They recognised that GPs wished to raise the standard of care for their patients by achieving and utilising the saving but not how those savings might be utilised. They did not report any less positive aspects at practice level on reasons for going fundholding as they focused very much on the introduction of the reform and the financial incentive to participate.

#### **4.3.2 Measuring the Impact of Fundholding: Incentive and Waves**

Studies had tended to concentrate on early waves and initial impact (for example, Glennerster *et al.*, 1992; 1994; Audit Commission, 1996a; Audit Commission, 1996b; Ellwood, 1996; Llewellyn and Grant, 1996). It was widely reported that practices were motivated to volunteer early on in order to take advantage of any early incentives that might diminish for later waves or be lost if fundholding were to become compulsory. This pre-occupation with early waves and financial incentive may have contributed to the lack of in depth consideration of broader and more convoluted reasons why the practices went fundholding. Studies concentrated on hard data such as list size and practice demographic in the earlier years of fundholding and research on the phenomena reduced in frequency as fundholding became more widespread and implementation was less of a novelty. Some studies confined their data to specific waves such as Glennerster *et al.* (1993) comparing first wavers to third wavers. It can be concluded that more studies involved early waves than across or towards the closing years of fundholding.

Thus, conclusions about reasons for going fundholding were largely based on the simple aspects of the reforms, that is, incentive and waves. The impact of the incisive change that fundholding brought to the operation and accountability of general practice may have been obscured by what is easily measured. However, caution was suggested due to anticipated measurement difficulties (Moon *et al.*, 2002), including the practice demographic, wave, health authority policies. The more simplistic research avoided the many variables contributing to the decision to go fundholding and those factors which could not be measured which is, perhaps, not surprising given the multiple factors behind fundholding (see Figure 2.1). Nevertheless, fundholding studies emerged in the health policy and new public management literature (see Iliffe and Munroe, 1993; Ellwood, 1996; Ellwood, 1997; Glennerster *et al.*, 1994; Laughlin *et al.*, 1994). Some later reflections suggested caution on relying on those early fundholding research findings at the risk of over generalising from common unsubstantiated observations, for example, from allegations that fundholding was more dominant in affluent communities, or was inversely related to deprivation factors. Therefore, whilst the easiest variable to isolate and measure was the wave that each practice went fundholding, taking such a positivist approach may have actually constrained fundholding studies and encouraged less adventurous research that admitted to the diversity and social implications of the scheme.

The phase one evidence suggests waves were only important to these GPs in that they were a barrier to accessing the reforms and therefore financial incentives and benefits. Waves had differing criteria that eased wave by wave to encourage more to take up fundholding. Some studies have looked at the dimension of the historical geography of uptake across the waves, (e.g. Moon *et al.*, 2002) and found that there had been an overall exaggeration of cause and effect, such as in relation to the inverse relationship between fundholding and population deprivation and no evidence of stereotypical affluence amongst fundholding practices. Indeed, Moon *et al.* (2002) argued for further analysis of individual GP behaviour and consideration of practice innovation history, demonstrating the rich tapestry behind each practice's choice. Within this study's group of practices there is at least one instance, *prima facie*, of a dominant GP and that perhaps that could be investigated further to address Moon *et al.*'s (2002) concerns and also by considering the context of the decision. It is now important to

investigate the multiple reasons within the cases through further data analysis to try to expose the richer reason for going fundholding beyond incentive and waves.

### **4.3.3 Multiple Practice Reasons for Going Fundholding**

On further analysis of the case studies multiple major factors for individual practices in deciding to go fundholding are revealed. Table 4.2 shows a complex mix of reasons for going fundholding and enables comparison between practice and warrants further investigation and analysis. For some practices there was one clear, overriding aim, whereas in others there appear to have been several factors at work. In this study, having interviewed both lead partner and fund manager there is some assurance that the reasons for going fundholding are not the biased view of one individual player notwithstanding the case where the lead partner is dominant, for example, practices E and J. It can be seen that whilst financial incentive is broad there are multiple factors contributing to the financial incentive. There was financial capability to do more within the practice boundary, for example by improving premises, and beyond it, in the case of protecting hospitals through contracting. However, there were other areas of focus, such as an aversion to the alternatives of not being fundholders.

### **4.3.4 Positive and Negative Reasons for Going Fundholding**

Glynn *et al.* (1992) briefly indicated that there might be negative reasons for going fundholding as well as positive because some practices thought it was better to be in the scheme earlier than later. Some studies of fundholding did recognize diversity in practices for going fundholding (see Table 2.4) but did not consider multiple reasons at practice detail level. Ennew *et al.* (1998) classified the motives for going fundholding as either positive (recognizing the opportunities fundholding brought), or negative (aligned to reluctant participation by practices) and provides a framework for thinking about the broader range of reasons described in Table 4.2 in this study. Ennew *et al.* (1998) focused on the nature and context of entrepreneurship demonstrated by GPs. The study defined entrepreneurship as the exhibition of behaviours associated with reducing inefficiency, price-quality arbitrage and innovation. It was seeking defined behaviours, according to the role and actions of an entrepreneur, rather than an exploratory study. Bearing in mind the pre-conceived

framework of that study the negative/positive categorisation in the study is still a useful tool to analyse the multiple factors that emerged from the interviews in this study. Each practice reason in Table 4.2 has been assigned a positive or negative symbol according to category created by Ennew *et al.* (1998). The caveat of relying on the study is its focus on the premise that fundholding reforms create opportunity and caused entrepreneurial behaviour and activity by GPs. It concluded that fundholders in the positive camp were behaving as true entrepreneurs, grasping fundholding as an opportunity whilst those in the negative camp were *reluctant* entrepreneurs entering fundholding. The measure of entrepreneurship was also restricted to the narrow fundholding behaviours of x efficiency, price arbitrage and innovation. Although GPs were behaving entrepreneurially there are other factors that require exposition which were evident in earlier studies (Table 2.2) and found in this study (Table 4.2). Further, entrepreneurship in the private and social sector may not be a relevant analysis in the context of GPs.

What is deemed negative for one GP in terms of defined entrepreneurship may be positive for another GP. Entrepreneurship is not a required characteristic for volunteering for fundholding as Table 4.1 and 4.2 begin to demonstrate. For example, the non-IT literate GP in Practice A who welcomed the ability to develop IT may be entrepreneurial yet another may have perceived IT and the associated management information system as reducing autonomy through the transparency of accounting and information technologies, for example, recording referral activity. Ennew *et al.* (1998) classified the development of IT as a negative reason for going fundholding compared to the positive entrepreneurial activity of developing patient services as part of innovation. While the entrepreneurship model may have been a good tool to analyse why GPs go fundholding in the early stage of fundholding research it is too limited when the factors in Table 2.2 and 4.2 are considered. For example, developing IT can be part of the strategic development of the practice and hence not a 'bad' thing. There is also some question of whether taking financial incentive can be associated with entrepreneurship and indeed might be confused with entrepreneurship.

<b>Practice: Major Factors in Going Fundholding</b>		
<b>Practice</b>	<b>Wave</b>	<b>Positive (+ve) and Negative (-ve) per Ennew <i>et al.</i></b>
A	3rd	Use savings to develop facilities. (+ve) Improve computer systems. (-ve) Protect patients from effects of two-tier system (-ve)
B	3rd	HA pressure. (-ve) Protect local cottage hospital. (-ve)
D	3rd	Practice partnership felt it ought to go fundholding (-ve) Updated computer systems. (-ve) Access to advances in health care. (+ve)
E	1st	Develop computer systems. (-ve) Develop the organization by increasing human resource. (+ve) Enthusiastic individual. (+ve)
F	2nd	Protect local hospital. (-ve) Direct funds to local hospital. (-ve)
H	1st	Early benefits. (-ve) Usually innovative. (+ve) Alternatives worse. (-ve) Improve practice management. (+ve)
I	3rd	Influence health care but overall ambivalent. ( <b>neither +ve or -ve</b> )
J	1st	Committed individual. (+ve)
L	4th	Develop in-house services. (+ve) Speedier treatment of patients. (+ve)
M	6th	Shares premises with fundholding practice. (-ve) Non-fundholders' patients suffering. (-ve)
N	6th	Keen individual (but small practice). (+ve) Develop patient services. (+ve)
O	6th	HA pressure. (-ve) Develop services and facilities. (+ve)

**Table 4.2 Major Factors in Going Fundholding for the Practice**

Indeed the financial incentive is recognized as reduced in the older waves. For example, it could also be viewed that financial incentive aligns more with Harrison and Pollitt's (1994) seeking of occupational control a one of the three notions of professionalism in the welfare state because in this study the budget and possibility of savings was not an end in itself but facilitated other things.

Ennew *et al.*'s (1998) positive reasons for going fundholding included the opportunity to improve patient services, for example through the development of outreach clinics, the improvement of physical amenities or the reduction of waiting lists. Negative reasons included peer, practice and/or health authority pressure, computerisation and the availability of early financial inducements which are clearly at 'odds' when contrasted to entrepreneurial behaviour hence deemed negative elements in the study. In fact, incentives and real management tools for better general practice when deemed as negative ignored how GPs themselves went about fundholding because fundholding does not fit the narrow investigative view of entrepreneurial activity. This substantiates the assertion made from the literature that the factors behind fundholding as a NPM reform (Figure 2.1) are important in the context of NPM application and justifies the necessity to approach the study from an interpretivist paradigm, and with as little pre-conceived assumptions as possible.

The interviews reveal that the fundholders, allowed to talk freely about the scheme through open questions, actually found those 'negative' motives as positives in the going fundholding, for example Practice A viewed computerisation as positive. The analysis into the positive and negative classification can be summarised by plotting relative positions of the practices in this study on an axis according to the exhibition of negatives and positives within each practice. For example, Practice H has two positive and two negative factors while Practice L has two positives and is therefore, more positive according to the Ennew *et al.* (1998) classification. There is no weight allocated to the positive negative factor but is it useful in conceptualizing the observations in Table 4.2. To help the allocation the reasons themselves are also considered in terms of ambience, either protecting or developing the practice, a contrast marked for example between practice F (protecting) and practice E (developing).

Thus in Figure 4.1 the practice reasons are broadly plotted into relative qualitative positions rather than just a numerical addition of positives and negatives, for example Practice H and O are neutral but the descriptions in Table 4.2 when compared indicate

Practice O presents a more negative position than H because they had the added external HA pressure.

F<sub>3</sub> B<sub>3</sub> A<sub>3</sub>                      M<sub>6</sub>    D<sub>3</sub> I<sub>3</sub> O<sub>6</sub>    H<sub>1</sub>                      N<sub>6</sub> L<sub>4</sub> J<sub>1</sub>    E<sub>1</sub>

---

**Negative**

**Neutral**

**Positive**

*Protecting*

*Developing*

**Figure 4.1 Going Fundholding: Practice Reasons and Waves**

The negative reasons, represented as reluctance, by Ennew *et al.* (1998) are evident in this study where there are practices who were forced into fundholding as they protected either the practice, for example Practices D and M, or the local hospital, in the case of Practice F. Some practices were encouraged into fundholding by the health authority (Practices H and O) and thus received a push. On the other hand an enthusiastic GP, such as in Practice J and E, drags the practice into the scheme through their enthusiasm and drive, leading the practice when there are often less committed partners within the practice.

Just briefly returning to waves and the contention here that much of the earlier research focused too much, firstly, on the nature of the reforms and, secondly, the assumption of entrepreneurship, it is notable that all first wavers in the study are on the positive side (E, H, and J) in Figure 4.1. Practice positivity in terms of entrepreneurship was indeed strong for these pioneers. This suggests that early wave fundholders exhibited more entrepreneurial characteristics than later waves, but not exclusively so (Figure 4.1 practices L and N). Later wave practices in the study reveal a more protective than entrepreneurial stance possibly based on an evaluation of predecessors e.g. going to preserve local hospital position. Early waves were heavily incentivised by better financial packages and therefore those who wished to develop saw the new funding as a way to secure development. A frank comment from a first wave fundholder depicted the generosity of the management fee in the early stages as

‘a bribe to get doctors into the fundholding system’ (LP<sub>1</sub>).<sup>4</sup> Not all early fundholding practices may have been bribed or may not have even recognized the bribe. Intending to do the best for the patient is a clear factor in the practices as part of the functionality of the GPs professional arrangements (Harrison and Pollitt, 1994). For some GP practices the bribe was acceptable, even if it was linked to infrastructure benefits and thus more remote from direct patient impact, such as Practice E, demonstrating occupational control. Generally across all waves, it seems perceiving patients might suffer relative to other practices’ patients and externals pressure was not a price worth paying by not being part of fundholding.

#### **4.3.5 The Significance of the Lead Partner: Choice**

None of the case studies showed unanimity across the collective partnership for agreement to going fundholding and there is evidence of significant influence by some lead partners in the decision. This study has shown that existing models of entrepreneurship on the public sector scheme of fundholding, have taken theory and applied it with pre-conceptions of the private sector, a more deductive approach may be inappropriate. Studies were taking a theory and applying it to a new context, an ‘outside’ theory looking ‘in’ on the application to managerial matters in primary care. That is an interesting perspective and does contribute to understanding why practices became involved in fundholding but it does not do justice to the choices facing the practice: there are other issues in this study such as who adopted the lead partner role and why. It seems the literature either looked at the ‘practice’ choosing a financially incentivised scheme or the individual GP views of the practice, as spokesperson for the practice, without addressing the key players and drivers that allowed a practice to enact the scheme. The evidence here shows that studies thus far ignored the bridging role of key players between going fundholding and actually being a practice of fundholders; a mission undertaken by adopting the role of lead partner. It raises a third research question:

#### **RQ 3 Why did the lead partner undertake that role?**

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<sup>4</sup> LP<sub>1</sub> refers to the Lead Partner from Practice I, and so on.

Early studies did not examine why the lead partner undertook the role, although there was some research on roles taken (Newton *et al.*, 1993). This is further evidence that with hindsight too much research at the time focused on the reforms and mechanics of that change to general practice. Further, studies focused on the *practice* itself rather than key players.

#### **4.3.6 Motives for Going Fundholding: Internal; External and Personal**

The practices in this study are not an objective entity but are made up of individuals constructing a social world. Policies change quickly in the NHS, usually when there is a change in government or a reshuffle of ministers and as a consequence generate interest from researchers. Fundholding, as one such policy was researched for early impact with little analysis to inform the future. Moreover, small regard was given to the individual bringing those policies to life: who were they; why did they get involved? This ‘lived experience’ (Silverman, 2004) of the actors in fundholding implies that labelling of the phenomenon into one category or the other, in this case, of reluctance and/or entrepreneurial activity; positive or negative reasons may oversimplify it. Published but evidently limited research of why GPs went fundholding was useful because it began to show the reality of why GPs go fundholding, however the studies lack depth of analysis in order to conceptualise why a member of this profession chose to be active as lead partner in the process of the reforms.

In order to add to the understanding of fundholding and the factors that influenced the decision to be fundholding it is useful to analyse at a more detailed level (Table 4.2). However, there are three clear categories of reasons for going fundholding revealed in the interviews relative to the practice which help put that ‘lived experience’ of choice in context. In Table 4.3 the reasons for the practice going fundholding can be allocated to one of three categories: internal practice factors; external factors pertaining to the practice and, thirdly, personal type reasons such as a committed individual within the practice itself. These ‘grounds’ for going fundholding enable a cursory categorisation that sets the scene to investigate further the multiple factors that inter played during this initiative in primary care.

<b>Internal to the Practice</b>	<b>External to the Practice</b>	<b>Personality</b>
Develop facilities/infrastructure	Protecting Patients from two-tier system	Committed individual
Improve computer systems	Pressure from Health Authority	
Get early benefits/savings	Access advances in healthcare	
Improve practice management	Influence healthcare	
Protecting patients on the list generally	Speedier treatment for patients	
Develop in-house services		

**Table 4.3 Conditions for Going Fundholding: Internal, External and Personal**

Further, this analysis, setting aside the simple allocation of the negative and positive elements, begins to shine some light on the ‘murkiness’ in Figure 4.1 as the practices have been allocated along a continuum. Commensurate with Glennerster *et al.* (1993) choosing fundholding is based on a number of key reasons: improving quality of service; referral freedom; service development; budgetary freedom; money and computing. However, for the first time under the umbrella of fundholding research there is a recognition of the personal, private, aspect to choosing to be fundholding. Glennerster *et al.* (1993) referred to this as the ‘next mountain’ for GPs often reflecting a GP who was “bored with general practice” but that study concluded that it was a phenomenon limited to younger doctors in their thirties. Similarly Ennew *et al.* (1998) had concluded that the reluctant entrepreneurs were often junior partners allocated the tasks of fundholding and managing it on an *ad hoc* basis. Though ages were not recorded of GPs in this study the majority were mid-career and beyond and there was clear evidence of different levels of involvement in terms of scope, depth and allocation of the resource of time to fundholding. Thus where other studies have stopped at a dualistic framing of positive and negative reasons for practices the data here reveals an opportunity to contribute to the literature through recognizing that reasons are more intricate through a third element, being the personal aspects of the GP in its own right. One extreme from the data is the ‘committed, even dominant

individual' which emerges from the data in this study. Crucially, if one of the categories is a committed individual it raises the key question of why do some GPs become lead partners and do they get involved in management as lead partners? That Glennerster *et al.* (1993) refer to the 'next mountain' confirms that personal aspects are influential.

Some lead partners are emerging as instrumental within the practice choice for fundholding but exclusively as there are internal and external factors that influence the decision. Drawing attention to the lead partner motivations will enhance our understanding of fundholding and new management initiatives in the NHS. Fundholding brought a new managerial aspect to an established professional with existing functionality of professional arrangements, which required a lead partner to step into an additional role and therefore requires some attention.

#### **4.4 Going Fundholding: Becoming Lead Partner**

The emergent finding that the lead partner was a significant factor in going fundholding will be examined before investigating the role of accounting addressing research question 3. Tables 4.1, 4.2 and 4.3 shows there are multiple reasons for going fundholding and the indications that the mix is complex. Table 4.1 shows that practices in the study vary in their overall reason for going fundholding. Table 4.2 introduces positive and negative reasons and enabled Figure 4.1 to show how practices go fundholding to protect and develop, the latter usually combined with an enthusiastic and committed GP in the lead partner role. Whynes *et al.* (1999) suggested that not all entrepreneurial GPs were fundholders and not all fundholders were entrepreneurial. Thus, if not entrepreneurial, what were the characteristics of these pioneering GPs that made them active in fundholding? It may be that they were exhibiting occupational control. If not driven through entrepreneurship there must be something else contributing to the choices they were making and why they were making them? These questions need addressing in order to add and compare to existing claims about entrepreneurial GPs and identifying the background to becoming lead partner is important.

Table 4.4 summarises the background to becoming lead partner and enables the identification of a number of themes. Lead partners in practice A (LP<sub>A</sub>) and L (LP<sub>L</sub>) were involved in proposing to go fundholding, or the preparation of the papers for application, thus suggesting that the role followed on from their early involvement. A significant number of practices (B, E, N and O) had partners who were traditionally active in practice development, either in technical innovation e.g. IT systems or other initiatives and hence came into the role on those strengths. Partners from practices D, H and I referred to coming from the ‘business side’ of general practice either explicitly or stating they enjoyed organizing deals. Only one future lead partner, in practice J, explicitly stated support for the policy as a reason for taking the role on. Three partners contended they were in the role by default (F, I and M) although the partner from practice I somewhat guiltily confessed an interest in the ‘business side’. There is some negativity and reluctance surrounding some of the partners about being in the role of lead partner. Partners in practices I, F and M did not show enthusiasm about the role, although LP<sub>I</sub> did have an interest and enthusiasm to be involved in the business side. Lack of enthusiasm about being lead partner in these may arise from the negativity in the practice going fundholding (see Figure 4.2). Not all partners with a lack of enthusiasm were in practices that were protecting, for example LP<sub>I</sub> was ambivalent in a neutral practice. LP<sub>F</sub>, on the other hand, was in that role by default in order to protect the local hospital. Some of the positive reasons for going fundholding through utilising the incentives were for both the good of the patient and to influence health with a visionary lead partner, for example in practice L. However, the interviews indicated that GPs were not always behaving altruistically for the practice or other partners’ perspective. The widespread presence of ‘negative’ reasons suggests a lack of enthusiasm on the part of many fundholders, although there were some who saw positive features (e.g. LP<sub>E</sub>, LP<sub>J</sub>). It should also be noted that others admitted that their initial negative views of fundholding had been mollified with experience (e.g. LP<sub>B</sub>, LP<sub>M</sub>).

Newton *et al.* (1993) studied first wave fundholders and concluded that GP’s were influential in the decision to go fundholding but the GPs contribution was less so in the day to day task and contract regulation. This implies that GPs, once fundholding, did not get involved in the management of it on a day to day basis at operational level or contracting which is a more strategic level. There are instances from the interviews

<b>Practice</b>	<b>Wave</b>	<b>Major Factors in Going Fundholding</b>	<b>Background to Becoming Lead Partner</b>
A	3rd	Use savings to develop facilities. (+ve) Improve computer systems. (-ve) Protect patients from effects of two-tier system (-ve)	Had done paperwork for application process.
B	3rd	HA pressure and force. (-ve) Protect local cottage hospital. (-ve)	Previously involved in technical development.
D	3rd	Practice partnership felt it ought to go fundholding (-ve) Update computer systems. (-ve) Access to advances in health care. (+ve) Develop dilapidated facilities (+ve)	Enjoys organizing deals.
E	1st	Develop computer systems. (-ve) Develop the organization by increasing human resource. (+ve) Enthusiastic individual. (+ve)	Enthusiast for innovation and practice development.
F	2nd	Protect local hospital. (-ve) Direct funds to local hospital. (-ve)	By default.
H	1st	Early benefits. (-ve) Usually innovative. (+ve) Alternatives worse. (-ve) Improve practice management. (+ve)	Leanings towards business side.
I	3rd	Influence health care but overall ambivalent. (neither +ve or -ve)	Interested in business side, and no other volunteers.
J	1st	Committed individual. (+ve)	Support for GP fundholding.
L	4th	Develop in-house services. (+ve) Speedier treatment of patients. (+ve)	Originally proposed.
M	6th	Shares premises with fundholding practice. (-ve) Non-fundholders' patients suffering. (-ve)	Others not interested.
N	6th	Keen individual (but small practice). (+ve) Develop patient services. (+ve)	Took initiative.
O	6th	HA pressure. (-ve) Develop services and facilities. (+ve)	Volunteered.

**Table 4.4 Major Factors in Going Fundholding and the Background to Becoming Lead Partner**

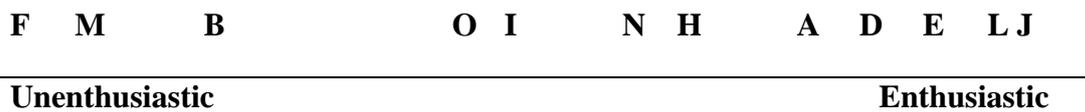
of doctors whose practices continued to participate in fundholding, but only with reluctance, because of some overriding tactical reason (for example see Practice F) or the commitment of the lead partner.

It is becoming clearer that the conduit between the partnership and fundholding is the lead partner and it is clear from the analysis so far that not all lead partners were positive about starting or continuing in that role adopting the linking-pin behaviour (Likert, cited in Newton *et al.*, 1993). Once the practice had gone fundholding there is scope for the lead partner to enact that role as he/she sees fit and initial reasons for taking on the role may have influenced how the lead partner shaped their role. This requires further consideration. Therefore in order to answer why the practice chose to go fundholding the lead partner role needs some explication. However, in the first instance it is necessary to incorporate the lead partner into the positive/negative analysis of why the practices went fundholding because it has emerged as an important, and previously, an unaddressed variable in the decision to go fundholding in other studies.

#### **4.4.1 Lead Partner Enthusiasm**

Table 4.4 is a valuable extension of Table 4.2 as it identifies the background to becoming lead partner for each practice therefore it brings in the personal element (see Table 4.3) and can start to explore the ‘next mountain’ factor introduced by Glennerster *et al.* (1993). The reasons for going fundholding and the role of those adopting lead partner positions may be intertwined; there is early evidence in at least one case, that of practice J. The variety in the background to becoming lead partner suggests a need to move on from single dimensional analysis. The single-dimension of positive-negative in the practice context does not capture the richness of the reasons for going fundholding and getting involved in the NPM experiment. In Figure 4.3, lead partners are allocated along the axis according to their relative enthusiasm for the role and generally how they embraced it based on the initial analysis in Table 4.4 and case studies. Enthusiastic individuals are allocated that label when they tended to express a self interest in a leadership role, practice ‘business’ development and in more managerial things, including for example LP<sub>1</sub>. Lead partners in practice F and J are the extremes. Lead partner F arrives in the role by default and hence is

unenthusiastic. The word unenthusiastic is deemed here to be better in the analysis than ‘not interested’ which fits less well as they are in the role already. LP<sub>F</sub> is classed as the most unenthusiastic, being in a default position characterized by the fund manager realistically being the ‘lead’ in the practice, the role for the GP in fact a non-event evidenced by choosing not to be interviewed as he did not have anything to add to what the fund manager would say. LP<sub>M</sub> was also in the role by default being placed in an untenable position of not being able to stay as non-fundholders whilst sharing premises with a practice that was but enthusiastic to do the job properly having had to take the job on. LP<sub>B</sub> is also at the unenthusiastic end, despite being active in practice development and arriving in the role based on past history for getting involved in developmental things, he categorically stated he was reluctant to do so, having no interest in it.



**Figure 4.2 Lead Partner Enthusiasm for Taking on That Role**

Lead partners in practice N and H were neutral relative to the other practices in terms of fundholding but did not express a particular distaste for it or resistance to taking the role on. Lead partners in practice O and I can be described as absolutely neutral in the context of lack of challenge for the role and overall ‘no opinion’. Ambivalence (LP<sub>O</sub> and LP<sub>I</sub>) is characterized by the volunteers who were neither in that position by default or demonstrating enthusiasm for the role. Thus, the central position represents a neutral partner such as that in Practice I who wanted the role above others in the partnership but without a keen appetite for fundholding itself.

Partner J supports fundholding unreservedly and hence is the most enthusiastic on the continuum, harnessing the policy of fundholding and as the fund manager stated ‘pushing’ it through the practice. LP<sub>L</sub> is less enthusiastic as he is not driven by the essence of fundholding but was highly committed in order to use the vehicle of fundholding to develop in-house services. LP<sub>L</sub> is classed as more enthusiastic than

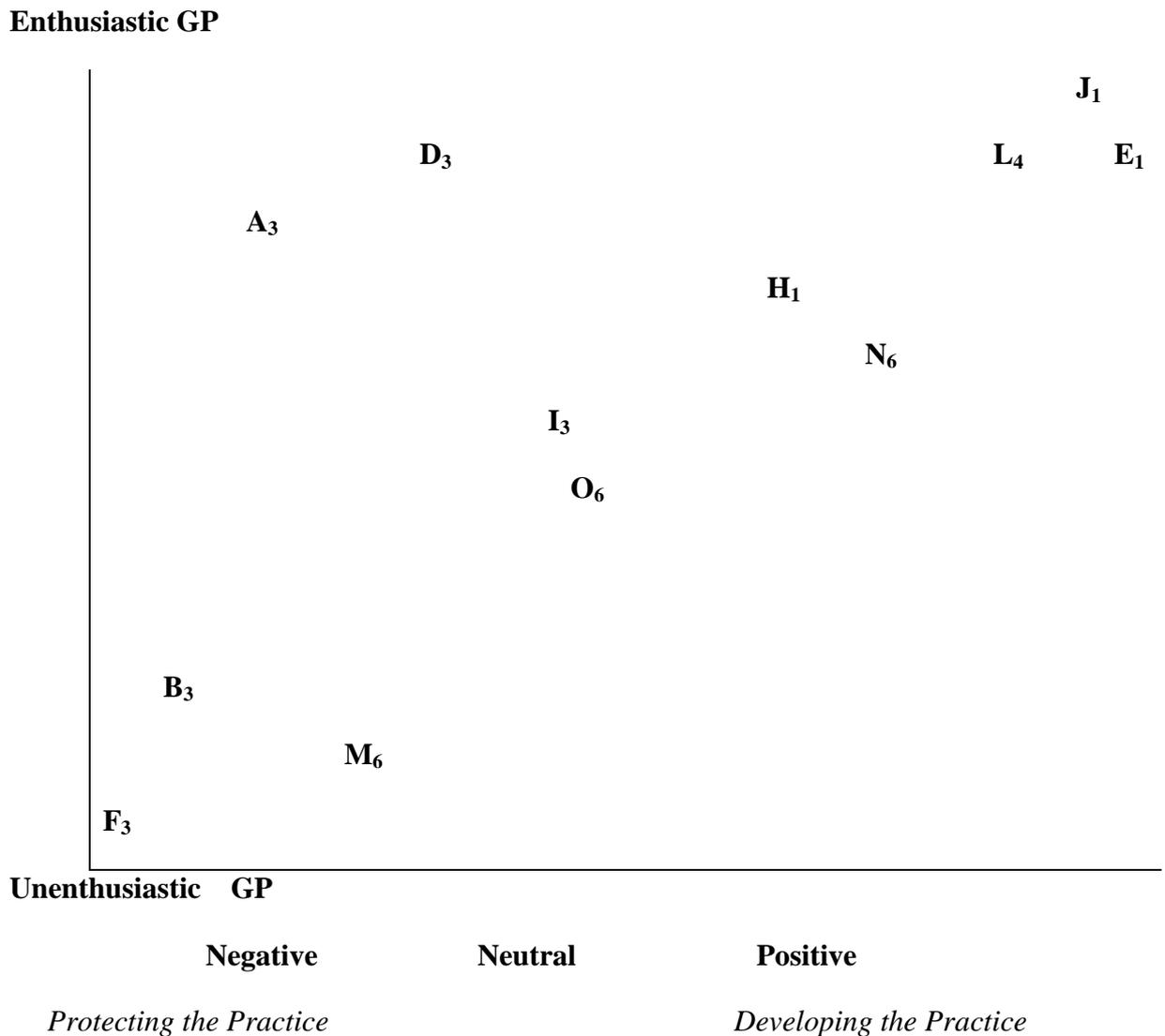
LP<sub>E</sub> as fundholding was another innovation he chose to grasp in addition to cumulative opportunities for GPs to develop their practices. LP<sub>D</sub> was in a similar position of enthusiasm to LP<sub>E</sub> but less expressive of the benefits of fundholding itself and more keen on the opportunity to do more ‘deals’ for the practice. On the other hand, LP<sub>A</sub> can be attributed as less enthusiastic as the role was followed on from the administrative paperwork task completion and lacked the verve of the lead partners allocated to the right of him on the continuum.

Figure 4.2 goes beyond practice reasons recognizing the influence and the potential impact of the person adopting the role of Lead Partner. This is a vitally important contribution because of the importance of human actions that were creating fundholding as it unfolded. It is this lead partner role that is the vessel between the practice and the individual partnership. GPs all of whom are classed as fundholders, in the majority of literature may not all be fundholders at all, other than by being a partner in a partnership that had signed up for fundholding. The possible variability in significance of the lead partner has emerged in the study and raises questions about how fundholding is lived.

#### **4.4.2 GPs as a Unit of Analysis**

The lead partner dimension in fundholding needed bringing to the fore to aid the interpretation of why a practice which is socially constructed chose to be fundholding. Therefore to present a two-dimensional analysis the two figures are assimilated in Figure 4.3 as part of qualitative analysis. The relative positions from Figure 4.1 and 4.2 were plotted as the reasons for going fundholding by the practice were deemed important (Figure 4.1) and the relative enthusiasm for going fundholding by the GPs within the practices in this study (Figure 4.3). The practice position is found on the x axis and the GP position on the y axis.

LP<sub>F</sub>, the most unenthusiastic, is in a practice that went fundholding in order to protect whilst LP<sub>J</sub>, the most enthusiastic is in a practice that chose fundholding for developmental reasons. The diagram seeks to merge the practice reasons for going fundholding and the enthusiasm of the lead partner as one cannot be divorced from



**Figure 4.3 Going Fundholding: Practice and GP Orientation – taking on the lead partner role**

the other and enhances the study by investigating why the lead partner took the role. Prima facie, in Figure 4.3, there is some correlation between the practice reasons for going fundholding and the enthusiasm of the lead partner.

This is reinforced by the absence of any practice in the right bottom corner where a practice might have positive reasons for going fundholding but an unenthusiastic Lead Partner. However, there is also an apparent anomaly in the top left hand corner

(Practices A and D). Both practices A and D are third wave practices and on further investigation of the data went in that wave for differing reasons: Practice A being ready, previously being too small for the first wave, and too unsettled in terms of partnership changes for the second wave; Practice D being eligible from the first wave onwards but in some partnership turmoil up to the decision to go and being ambivalent about it. Both practices did appear to have enthusiastic GPs and negative reasons overall for going fundholding, it appears that they were third wave, is mere coincidence. However both have the practice context of some in-house distractor that constrains the decision to go earlier in order not to upset the practice equilibrium further before the third wave. These practices may have been more enthusiastic about fundholding than it first appears.

The positive correlation between the degree of lead partner enthusiasm and positive versus negative reason for going fundholding challenges the value of any two-dimensional analysis. It seems that the reasons for the practice having gone fundholding and lead partner enthusiasm are linked, that is, practices going fundholding for negative reasons were led by unenthusiastic GPs and practices going fundholding for positive reasons were led by enthusiastic GPs. That would seem logical but that conclusion is too simple. Firstly, this analysis shows that GP practices may be fundholders but not all GPs are committed fundholders as the lead partner role takes varying degrees of commitment. Even lead partners may not be committed fundholders which has implications for the ambitions of accountability under NPM and the aims it seeks to achieve. Further, GPs did not have to become lead partners so why did they? Why was the lead partner role taken? The evidence thus far contradicts the study that found junior partners took lead partner roles on the basis no other partner would. Crucially, why would an unenthusiastic professional adopt a role in the management of fundholding and hence involvement in the management of secondary care via the internal market mechanism? The reasons for going fundholding are broadly consistent with the functionality of professional arrangements but there seems to be some element of occupational control at play, seeking congenial working conditions and perhaps autonomy. Such differing degrees of enthusiasm are evident from Figure 4.3. The lead partner role is about choice and for that reason there is extra justification for thinking more about the GPs. However,

before venturing further into the GP in a lead partner role as possibly being more important than it first seems, how they got there and how they enacted the role as a result of being in that position, it is worth reflecting on the two-dimensional analysis before rejecting it.

#### 4.4.3 Exploring a Two-Dimensional analysis: Summarising the analysis

Thus far, the analysis indicates that:

- Some practices went fundholding for positive reasons and tended to be led by enthusiastic GPs. GPs appeared to be *opportunistic* and in an entrepreneurial mode in the context of *developing* the practice in a number of ways (see x axis on Figure 4.3) either technically or managerially, ‘pulling’ the practice (and possibly reluctant fellow partners) along with the momentum created by their enthusiasm.
- Some practices went fundholding for negative reasons but were led by enthusiastic GPs. GPs in such cases appear to be *guardians* and ‘push’ the practice along in the face of opposition from fellow partners and a negative set of factors for going fundholding.
- Some practices went fundholding for negative reasons and may be led by unenthusiastic GPs. GPs appear to *reluctantly innovate* while being ambivalent about the process itself.
- Some practices went fundholding for positive reasons and may be led by unenthusiastic GPs. Unenthusiastic GPs do not lead practices into fundholding for positive reasons; hence no practice is in the quadrant that might be termed *unenthusiastic leaders*. They may exist but the study did not find any.

#### 4.5 Naming the Types of Lead Partner

Figure 4.3 is divided into quadrants to enhance and explain the mapping in order to present Figure 4.4. Figure 4.4 is a two-dimensional analysis summarised by a two-by-two grid as a means of exposition of thought (Cowton, 1992) on the relative positions

of practices and lead partner combined. The grid structure enables the allocation of a lead partner type to assist in the interpretation and explanation of patterns emerging from the data about the importance of the lead partner.

<b>Enthusiastic GP</b>	<b>Guardian</b>  (A, D, I)	<b>Opportunist</b>  (H, N, L, J, E)
	<b>Reluctant Innovator</b>  (B, F, M, O)	<b>Unenthusiastic Leader</b>
<b>Unenthusiastic GP</b>	<b>Negative</b>	<b>Positive</b>

**Reasons for Practice going Fundholding**

**Figure 4.4 The Lead Partner and Practice Positions**

#### 4.5.1 Lead Partners: Guardians; Opportunists; Reluctant Innovators

Each quadrant in Figure 4.4 can be investigated by looking at the partners in each and summarised in Table 4.5. Practices A, D and E had a clear desire to improve the practice infrastructure through computerisation and increasing capacity of the estate to meet the needs of the practice. Along the vertical axis, LP<sub>A</sub> was very much focused on the contracting, data and computerisation (see Table 4.2) and the influence it might have on secondary care, protecting the practice and its patients as a microcosm of the NHS – being a **guardian**. This contrasts to LP<sub>E</sub> who it emerged was confident and adept in using government policy, working on a macro scale, organizing schemes to develop the organization for his own pleasure; he did not emphasize secondary care and protection of patients but did have a dominant personality in the ‘lead partner’ role. Practice E had a lead partner who was keen to influence primary health care and avoid the ennui suffered on a personal level by general practice and was opportunistic

in using policy for gain – being **opportunistic**. This contrasts with LP<sub>B</sub> who adopted a more strategic and managerial stance towards what fundholding could achieve by the practice joining the scheme. For practice B, with their perceived strong management systems, they sought to influence provision of care through commissioning to the extent of becoming a Total Purchasing Pilot, a **reluctant innovator** in order to protect the cottage hospital. Hence in Practice B the lead partner protected practice and patients with a more outward and external view compared to Practice A and thus exhibited behaviour of a reluctant innovator within the fundholding scheme of things. However, Practice B also had a strong practice manager/fund manager which may also contribute to a less of a need for an enthusiastic role. LP<sub>B</sub> could not be described as entrepreneurial though he supported practice innovation as he actually stated he was a reluctant adopter of the lead partner role and liked organizing deals.

#### **4.5.2 Exposing Reasons for Taking on that Role**

Table 4.5 organises the lead partners by classification alongside the major factors for the practice going fundholding for deeper consideration of why the lead partner took on the role and the context of the practice. By being a lead partner the domain of the GP as a professional may change as he/she chooses the lead partner role. In the first instance he/she is positioning to lead his fellow GPs in fundholding and secondly, may get involved in the change in the organisational nature of the practice, for example, by engaging with the role of accounting and budgeting, hence accountability to improve organisational performance at practice. In some cases, taking the lead role was accepted with some reluctance and viewed as something of a chore, to be undertaken because the partnership had identified some reason(s), positive or negative, to apply for fundholding status. Even when the challenge was an interesting one, and the GP was enthusiastic, it has carried an opportunity cost:

*It does inhibit me pursuing my other interests which I had hoped to do in my career. In some ways it's a side-track with me, some ways it's been a learning opportunity, it has changed me. In many respects it's changed me for the worse, there's no doubt, in some ways it's changed me for the better because I see a broader spectrum of things. (LP<sub>H</sub>)*

<b>Class</b>	<b>Practice</b>	<b>Major Factors in Going Fundholding</b>	<b>Background to Becoming Lead Partner</b>
<b>Guardians</b>	A	Use savings develop facilities. Improve computer systems. Protect patients from effects of two-tier system	Had done paperwork for application process.
	D	Practice partnership felt it ought to go fundholding Updated computer systems. Access to advances in health care.	Enjoys organizing deals.
	I	Influence health care. Ambivalent. A 'wait and see' approach.	Interested in business side, and no other volunteers.
<b>Opportunists</b>	E	Develop computer systems. Develop the organization by increasing human resource. Enthusiastic individual.	Enthusiast for innovation and practice development.
	H	Early benefits. Usually innovative. Alternatives worse. Improve practice management.	Leanings towards business side.
	L	Develop in-house services. Speedier treatment of patients.	Originally proposed.
	J	Committed individual.	Support for GP fundholding.
	N	Keen individual (but small practice). Develop patient services	Took initiative.
<b>Reluctant Innovators</b>	B	HA pressure. Protect local cottage hospital.	Previously involved in technical development.
	F	Protect local hospital. Direct funds to local hospital.	By default.
	M	Shares premises with fundholding practice. Non-fundholders' patients suffering.	Others not interested. An accidental fundholder
	O	HA pressure. Develop services and facilities.	Volunteered.

**Table 4.5 Major Factors in Going Fundholding and the Background to Becoming Lead Partner (reconfiguring Table 4.4)**

Thus the general impression from the qualitative interpretation of the research is that both practices and individual lead partners can differ in their reasons for having become involved with fundholding. Some responded to the scheme very positively while many, even though they ‘volunteered’ to become involved, viewed it somewhat pragmatically, even negatively, at the beginning, though in some cases becoming more positive with experience. Even where there was not active resistance, then, there was sometimes considerable reluctance.

The third research question asks why did the lead partner take on that role and the classification provides some summary of the characteristics of the lead partner. It is now time to approach the original and second research question; how was accounting implicated in the management of fundholding? What did the key players do with the new mechanism of accountability?

#### **4.6 The Role of Accounting in the Management of Fundholding**

The second research question sought to address NPM implications of accounting (Chapter 3) for the management of fundholding. It was assumed that it would play a significant role in achieving the aims of fundholding by creating calculable spaces and accountability for organisational performance. Osborne’s (2010) summary of NPM is a useful framework to consider how NPM’s features were embodied in the design of fundholding in order to show the link to the implications of accounting. To that end Table 4.6 summarises the main finding for research questions 1 and 3.

This section focuses on questions from phase one interviews relative to and about accounting. Lapsley (1991) argued for research of financial control in the NHS. The second research question aimed to uncover what the financial and accounting systems were creating and achieving in fundholding through views of the actors who made fundholding live: were they principally passive; might they be more than a bureaucratic means of recording financial consequence of professional judgment (Ezzamel and Willmot, 1993) hence enable; did Hood’s (1991; 1995) possible accounting implications of the doctrinal components of new public management have influence and impact in the management of fundholding such as more stress on cost

<b>Osborne's (2010) Summary of NPM</b>	<b>Fundholding</b>
Lessons from private-sector management.	Budgets, contracts, accountability. Management.
Hands on management.	Devolvement of management to GP practice as a cost centre. Involvement of GPs in management of the NHS. Creation of calculable space and accountability.
Focus on entrepreneurial leadership.	Some GPs exhibited entrepreneurial behaviour but that is a simplistic assumption. Evidence in this study found GPs were complex as lead partners and classified them as reluctant innovators, guardians and opportunists.
Emphasis on inputs/output control, evaluation and performance. Markets, competition, contracts.	Creation of internal market. Establishing contracts across the practice boundary with secondary care provider.
Management and audit.	Lead partner and fund manager roles. A management allowance. Audit of fundholding practices by health authority.

**Table 4.6 Implications of NPM for Fundholding**

identification and the bottom line, more use of financial data for management accountability and generation of more performance indicators?

The lead partner role was found to be significant in the earlier sections of this chapter in going fundholding but how would GPs organise and take to hands on management of funds across the practice boundary, and given that accounting is placed where it had not been before, what was the role of accounting in that management? Hopwood's (1986) perspectives demonstrate that accounting change does have potential and trajectories. Hood's implications for accounting set the potential for accounting in organisational improvement of the NHS and it is justified to explore in the context of fundholding to see how the role of accounting is manifested in the new domain with new purposes. Despite the technology of accounting being fundamental to the creation of the fundholding scheme through the creation of budgets, studies had not investigated the potential of accounting change. Moreover, for GPs the 'newness' of accounting fell across the boundary of the organisations of primary and secondary care. The response to funds being delegated to GP practices for the first time might

create visibility into the inner cabal of general practice to outsiders. How would the tool of accounting be formed and used by the fundholders and how would the key actors identify with the role of accounting?

In the next section the data is interpreted for each of the cases to explain the role of accounting. Both lead partner and fund manager interviews are analysed to corroborate an overall view for each practice, rather than one broad independent view of what accounting and accountability might contribute to fundholding.

#### **4.6.1 Questions about the Role of Accounting**

In this section the fund manager responses to the interview questions are summarised (Table 4.7). The lead partner and role of accounting information are then explored and discussed, practice by practice. Thus to add richness to the response to research question two, the fund manager responses in Table 4.7 inform the discussion of the information relationship between fund manager and lead partner and the role of accounting information in the management of fundholding.

It is important to note that this study does not assume fund managers are the existing practice managers in situ before fundholding. It was found that five of the eight fund managers interviewed from the twelve practices were recruited externally. External recruits tended to come from business rather than NHS backgrounds (only two of the five recruited externally were from the NHS). These data are incorporated in the Table 4.7. and is an important factor. They show that to achieve the objectives of fundholding, in some practices, that private sector skills were sought from outside the practice, consistent with NPM.

#### **4.6.2 The Fund Manager: Role of Accounting**

The questions for the fund manager, in addition to employment background, were in two broad categories:

(i) Information sharing relationship between lead partner and fund manager:

- What financial information do you pass on to the lead partner on a regular basis? How do you pass that information on?
- What does the lead partner do with the information you give him?

<b>Practice and Background</b>	<b>Advisors</b>	<b>Critical Aspects</b>	<b>Most time spent on</b>
<b>A (third wave)</b> <b>Recruited externally:</b> Senior Manager in Food and Drink Industry	Fellow Fund Manager; IT personnel	Fair funding; Contracting; IT systems; Budget reconciliation	Data processing (at outset); Monitoring and planning; Payments on contracts
<b>B (third wave)</b> <b>Recruited internally:</b> Tax Inspector; Education; Accountant; Practice Manager	Fellow Fund Manager	Contracting and Risk Management	Expense management (first two year); Monitoring of Budgets
<b>D (third wave)</b> <b>Recruited externally :</b> Retail	Fund-holding Group	Be well organised, forward looking and cope with change. Good negotiation. Day to day running.	Invoicing
<b>E (first wave) Recruited internally:</b> NHS including IT and practice management	Fund and practice managers; Health Authority; Year-end Auditor	Workable systems; Regular partner meetings; Communication	Accounts; Patient queries; Contracting
<b>F (second wave)</b> <b>Recruited internally:</b> NHS including senior positions	Colleagues	Monitoring contracts and getting the contracts right in the first instance	Administration
<b>H (first wave), I (third wave) and J (first wave).</b> <b>Recruited externally. :</b> Construction industry, purchasing and supply	Pioneer, thus nobody	“.. only learn with reality”; networking; getting the data on the computer	Question omitted in error during a complex interview
<b>L (fourth wave), M (sixth wave), N (sixth wave), O (sixth wave)</b> <b>Recruited externally:</b> Local authority, Health service. Hospital Management	Health Authority	Working in alliance with other practices	Financial side but not data input.

**Table 4.7 Summary of Fund Manager Responses**

(ii) The fund manager and fundholding:

- Who has advised you during fundholding?
- What are the critical aspects for fund management?
- What aspect of fund management do you spend most of your time on?

The questions were designed slightly differently according to the expected role of the fund manager and lead partner. The employment background of the fund manager was deemed important relative to how the role of accounting would develop, for example, an accountant in that role would be expected to emphasise accounting more than say, an IT person appointed to that role. Similarly, the lead partner perception of accounting and its importance may be dependent on the information he receives and does not receive. By asking both about the information and what they did with it, the researcher obtains a more accurate picture. The lead partner is also assumed to be the superior to the fund manager in the management hierarchy of fundholding, that is, he is reported to, at least to some extent, by the fund manager.

There is diversity in the role of the fund manager from the 7 respondents, from the 12 practices in the study. Two of the fund managers work for more than one practice, employed by 3 and 4 practices respectively. Only three of the seven fund managers were already employed by the practices when they came into the role. All internal recruits to the fund manager role were in the first three. External recruits were employed by all practice waves that were part of the sample (waves one through to four and six, but excluding five). Four of the practices were managed by one fund manager covering the fourth and six waves which was a characteristic of fundholding where smaller practices such as L,M,N and O (see Table 3.1) pool fund manager resources in order for breadth of knowledge and financial efficiencies, albeit creating a much larger administrative volume for fundholding purposes in terms of list size. The fund managers use advisors from the social and inner circle of fundholding with the exception of FM<sub>(L,M,N,O)</sub> who was appointed for his commercial contracting prowess to manage a large fundholding list size. It is notable that there are few external professional advisors e.g. management consultants cited as advisors.

### **4.6.3 The Fund Manager and Lead Partner: Role of Accounting**

The lead partner was asked four open questions focusing on three main areas in order to build a picture of the role of accounting: critical aspects; information; time spent on activities:

- What are the critical aspects of successful fund management?
- What do you do with the information received from the fund manager? And how do you receive that information?
- Is there any information that you do not receive that you would like to receive?
- What aspect of fund management do you spend most of your time on?

The forthcoming sections summarise the findings of each case.

#### **4.6.3.1 Practice A**

The lead partner delegated data collection and information gathering to the fund manager. The critical aspects of successful fund management were “good manager, good reliable data, and mistake free, ability to know exactly where you are at any time in the year” (*LP<sub>A</sub>*). Most of his time was spent on “strategy, individual problems, and individual cases” (*LP<sub>A</sub>*), very much a patient centric answer. Thus although he did not talk about accounting and budgets directly it was clear that he used the information from the fund manager, received on a month end basis, including the budgets, to assess the position of the practice. The desire for more detail by speciality, something he would have liked to help with negotiation and contracting, is an indicator of being active in the management of fundholding. It suggests that should the data show information that needed acting upon that some action would be taken. Further, he did not immerse himself in the data but had meetings ‘to talk it through’ with the fund manager.

The use of the financial information by the lead partner was corroborated by the fund manager who gives him “that information so he should be able to see where we are on a monthly basis....where we are going to be at year end” (*FM<sub>A</sub>*). However, the lead partners’ comments suggest that he was active on more than a monthly basis and is summarised as such in Table 4.8.

#### **4.6.3.2 Practice B**

This lead partner *looks* at the information and describes it as “an awful lot of accounting gobbledy gook - but you can looking at bottom lines and things, which is perhaps most interesting to us, or month on month, to stuff, budgets and how it’s going...I hope we see most of it”. He did not wish for any other information and was only worried about having ‘one man running the thing’ – and cited that as the critical aspect to successful fund management, ultimately “doctors are not management animals” (LP<sub>B</sub>). However, this lead partner does not seem to like the loss of control by having a fund manager clearly in charge of fundholding yet chooses to trust the fund manager. The comment of the fund manager support this interpretation who passed “very little” financial information on to the lead partner who only wished to know when something went dramatically wrong.

#### **4.6.3.3 Practice D**

For this lead partner the critical aspects of fund management were about change, using fundholding to change things for the patients. The fund manager passes lots of information on to the lead partner who is “very hands on... gets to know all the levels of contracts, where we are, sort of in relation to the performance of the hospitals”. Yet information is passed on “with a natter,” The lead partner also referred to these discussions, or ‘natters’, in relation to what he does with the information and did not describe any concrete activities. He either did not engage in fundholding activities or chose not to admit to it. However, there is some interest and discussion of contracting. When pushed by the interviewer he thought he spent most of his time on contracting and did not desire any further information. He categorically stated that he saw little point in being a partner in general practice and doing the accounts. Whilst the lead partner suggested he was involved in contracting he was clearly not involved in the management of fundholding within the practice through the use of data or day to day activities.

#### **4.6.3.4 Practice E**

According to the fund manager (known as the ‘Boss’) the lead partner does not ask for and therefore does not get any financial information at all, with one exception, when he asks the question ‘how many savings have we got left?’ The lead partner

confessed to relying on the practice/fund manager to keep him up to date. No evidence from the interviews suggested formal reporting mechanisms e.g. monthly reports – “if I need it I ask for it” (LP<sub>E</sub>). The critical aspects of fund management for the lead partner are “invisibility” but that any time he did spend was on negotiations and contract performance management.

#### **4.3.6.3.5 Practice F**

The lead partner of practice F did not want to be interviewed. The fund manager described all the partners as reluctant fundholders without enthusiasm and named a contrasting lead partner from another practice as an exemplar of an enthusiast. The lead partner does receive information on request – “we just keep in regular contact, whether we’re above or below what we anticipate.”

#### **4.3.6.3.6 Practice H**

The fund manager in practice H was also the fund manager in practice I and J. In respect of the financial information passed on:

*I run a very complex spreadsheet monitoring totally separate to fundholding software...fundholding software does not predict the complex contracts we have... it is double entry book-keeping...I do a monthly spreadsheet package...I do a two sheet hand written memo that gives you the keep principles and points...passed on in written format ...practice meetings each month... (FM, H,J)*

The lead partner from practice H uses the ‘matrix’ prepared by the fund manager, considering it adequate, and looks for under activity to see how the practice is doing. This fund manager was from a commercial contracting background and handled the fundholding process in a similar way – impartial from the medical aspects. The lead partner liked the data presented in this way, in order to spot trends, as the critical factor in fund management, supported by a good relationship with the fund manager. Most of the lead partner time is “just checking” and reading – “one sheet management”. However, the fund manager may be the same for practices I and J but the engagement with the fund manager and the management of fundholding is different.

#### **4.3.6.3.7 Practice I**

The fund manager passes everything on to the lead partner in the form of a spreadsheet and “he asks more questions, than the auditors do...” (FM<sub>I</sub>) – a sharp contrast to the lead partner in practice H. The lead partner also takes an interest and summarises the information for quarterly reporting to fellow partners. Finances were deemed straight forward, something the lead partner concurred with, “I look through and sign basically and I don’t get involved in the day to day figures, so basically I’m trusting – relying on him and the system” (LP<sub>I</sub>). The lead partner would have liked more information on waiting times as part of the information system, presumably to manage the fund better. The critical aspects for the lead partner were good contracts and negotiations.

#### **4.3.6.3.8 Practice J**

The lead partner in practice J receives the same information as that received by practice H and I but was elusive in describing what he did with it. Asked about critical aspects of fund management he said ‘go and ask the fund manager’ – “he does the entire contract monitoring for us”. However the lead partner did, earlier on in fundholding, spend the largest amount of his fundholding time looking individually at contracts but “now basically just read the excellent summaries”. It seems activity by this GP and lead partner has changed over time. As the fund manager does such a ‘good job’ the lead partner has stepped back from being active in the management of fundholding.

#### **4.6.3.9 Practice L, M, N, O – The Fund Manager**

Practices L, M, N and O share a fund manager as the practice worked in an alliance. At the month end the fund manager gives a full breakdown of the financial position, waiting list and breakdown of costs supported by regular meeting. The lead partner in practice L has a more formal relationship with the fund manager via a formal monthly meeting than for lead partners in practice M and N (a daily basis) and lead partner of whom he meets on a weekly basis. Lead partner M and N read the information and pass it back while lead partners L and O read it and keep it.

**Practice L**

This lead partner systematically reads the report and needs no further information. On questions of successful fund management the researcher was directed straight to the fund manager. The fund manager was in control of all things fundholding other than the lead partner keeping a watchful eye on the management of the lists to make sure they were not overspending.

**Practice M**

On seeing the information from the fund manager this lead partner will check for overspend. She has demanded other information on detailed referral activity and the fund manager has been able to provide that. On critical aspects of fund management it was the 'right manager' – "I am not a manager, I'm a doctor, and I wasn't trained as a manager...let him get on with it". On time spend on fund management – "I don't actually manage the fund...I get reported to".

**Practice N**

Critical to successful fund management was an enthusiastic lead (fund manager) who has imagination and dedication. The lead partner referred the researcher to the fund manager. He said that he 'passed' the monthly information and discussed it with the fund manager. He received all the information he asked for. On time spent – "I don't spend much time, once a year OK, when the contracting process is in progress".

**Practice O**

This lead partner separated the work out of the contract manager and the fund manager, regarding work with the contract manager as nothing clinical and not requiring any further information. Hence, the person this lead partner calls the fund manager is actually the practice manager "an interface between the accounting and medical side" with a separate contracts manager. Critical to both supporting roles to the fund manager was having the right knowledgeable person in place. He thought that he spends most of his time "signing invoices. It sounds very boring doesn't it really?"

#### 4.6.4 Making Sense of the Data: the Role of Accounting

NPM has accounting implications with operational significance and accounting change would be important in studying where accounting had not been before. Accordingly it is sensible to consider the accounting implications of fundholding using Hood's (1991; 1995) selection based on the doctrinal components of NPM. Table 4.8 shows an analysis that suggests that most of the day to day accounting, the recording and measurement, is in the hands of the fund manager. The fund manager creates the accounting of the scheme and makes it visible to the lead partner through the monthly and annual account reporting function but not all the lead partners interacted with that data or data that has been translated into information. Table 4.8 summarises and identifies the activities between fund manager and lead partner in order to later interpret the accounting implications from the data with implications for accounting and Hood's components as a framework. This analysis is an indicator of what the GP does as a professional taking a lead partner role (see Table 4.6) as a result of what accounting for the scheme measures. This will be further analysed in Table 4.9.

Practice and LP Type	A <sub>G</sub>	D <sub>G</sub>	I <sub>G</sub>	B <sub>RI</sub>	F <sub>RI</sub>	M <sub>RI</sub>	O <sub>RI</sub>	E <sub>O</sub>	H <sub>O</sub>	J <sub>O</sub>	L <sub>O</sub>	N <sub>O</sub>
<b>Day to day activities:</b>												
Strategy	X											
Contracting/Performance Management	X	X	X					X				X
List Management											X	
Individual Patient Fundholding Cases	X											
<b>Frequency of Interaction with data</b>												
Daily												
Intermittently within the Month	X					X						
Monthly	X		X	X					X	X	X	X
Quarterly			X									
Annually				X	X			X				X

**Table 4.8 Preliminary evidence of lead partner activity beyond inception of fundholding**

The role of accounting in the management of fundholding can be interpreted through the actions of the lead partner. The blank cells show no activity but even the shaded areas in the table highlight negligible involvement in fundholding after accepting a lead partner role for the themes that have emerged and been summarised in Table 4.8. LP<sub>O</sub> is determined as not active in fundholding as opposed to going fundholding which is consistent with the concept of being a reluctant innovator. But the remaining lead partners are active in the management of fundholding after inception of the scheme but how significant is the role of accounting? The themes interpreted and the categorisation is a help in analysing the data.

#### **4.6.5 What was the Role of Accounting in the Management of Fundholding?**

Overall it can be said that some of the lead partners are significant in going fundholding but may choose not to engage in any activity into the management of the lived experience. They delegate it to the fund manager, either actively or by ignoring fundholding. Table 4.8 shows that the role of accounting in the management of fundholding is different between lead partners and that the interaction with the fund manager varies. These activities are argued to be indicative of involvement in fundholding beyond taking the lead partner role and a further factor to consider is that GPs take on the role as guardian, reluctant innovator or opportunist.

At one extreme LP<sub>O</sub>, a reluctant innovator, is not active in fundholding and has a blocked column in Table 4.8. Notably, none of the reluctant innovators have a day to day role in this analysis. As group, reluctant innovators engage less frequently with the data and information from the fund manager on a monthly basis and are more likely to do something on an annual basis than an opportunist or guardian.

Opportunists lead partners are less likely to engage intermittently within the month than guardians and reluctant innovators with fundholding activities and management, but did monthly, largely on contracting and list management, hence outward facing fundholding activity. Guardians are more active in the management of fundholding on that outward facing basis and one guardian more so on internal matters, that is, individual patient cases. However, one guardian though involved in fundholding leaves all the data management to a fund manager.

Although accounting is in place in the practice for fundholding in accordance with improving organisational performance, consistent with NPM overall it does not loom large as part of the management of fundholding by lead partners who take on that role as ‘gatekeepers’. However, lead partners do take on different activities a part of the lead partner role which raises a more detailed fourth research question: how did the lead partner enact the management role; what did they do and how did they do it?

#### **4.6.6 Accounting Itself Does not Loom Large**

Accounting per se does not loom large in the management of fundholding by the key player in general practice, the lead partner, the professional in the practice. However, it does provide insights into how the fundholding pair of lead partner and fund manager work together. Table 4.7 considers Hood’s accounting implications to the summaries of interview data thus far. There is evidence of a stress on costs, their identification and relationship to the bottom line i.e. making savings or not. These GPs use the accountability information to varying degrees. Further although the role of accounting explicitly as a part of management accountability does not loom large the varying degree of lead partner involvement indicated by use of that information for varying degrees of hands on management does. Table 4.9 considers the role of accounting in the management of fundholding and its operational significance.

Given that nomenclature of ‘lead’ role it raises questions about what the lead partner does, how they are executing the management role? To some extent we have already seen what they do and how they do it through the analysis of the interview data providing insights and findings relative to research question 2, that is, about the role of accounting in managing fundholding. There were direct questions e.g. the fund manager was specifically asked what financial information he gave the lead partner and the lead partner asked what he did with it. There was frequently a mention of the budget and bottom line but lead partners were not actively engaging with or developing the information supplied through the accounting mechanism of budgets. Thus far a major finding is the significance of the lead partner but that the role of accounting was not significant for that player in fundholding and that lead partners chose to be involved in management in varying degrees once the practice was living fundholding.

<b>Hood's NPM: possible accounting implications</b>	<b>Hood's operational significance</b>	<b>Interpretation for Fundholding from the Data: Role of Accounting</b>
More cost centre units	Devolved budgets	Allocation of budget to GPs. Budgets are the accounting tool for NPM reform. Some GPs use budgets in management more than other GPs. The accounting is important to the fund manager to a certain degree. The budget is devolved to the practice and responsibility is devolved to the fund manager to varying degrees who produces summaries of day to day activities which are used to varying degrees by some GPs. Some GPs do not engage in fundholding activity despite being the lead partner.
More stress on cost identification	Distinction between primary and secondary public service	Clear evidence of contracting process being more important than accounting and costs themselves. However, the contract is part of the budget and accountability process. Cost within contracts do not receive much attention yet the contracting process does by the lead partners. Some lead partners talk about looking at the data and using it for contracting and negotiating.
Private Sector Accounting Norms	End of job for life, unmonetized rewards.	No apparent penetration from this research.
More stress on bottom line	Less job security	Many of the GPs did mention looking at the bottom line as part of the financial information received from fund manager but did not link to job security. This may be because the GP remained as independent contractor.
Fewer procedural constraints; More use of traditional data for management accountability	Freedom to management by discretionary power	Doctor's procedural constraints were not internal before. In fact, fundholding potentially increased constraints through visibility to those beyond practice boundary via budgets – exposed the internal workings of general practice.
More performance indicators and audit	Erosion of self-management	Yes. Fundholders were audited. Lead partners actually acting as auditors of the accounting information to see if 'where they [the practice] were at'. Some evidence from data of partners constraining referral behaviour of GPs that was out of line with practice policy.
Broader cost centres; blurring of pay and activity funds	Resource and pay based on performance	The creation and subsequent aspiration for savings to improve the practice and service to patients.

**Table 4.9 Consideration of Hood's accounting implications to the summaries of interview data**

#### **4.7 Doctors Getting Involved in Management**

There are differences in how lead partners engage in the management of fundholding after the initial phase of 'going'. From the very start for some lead partners, within practices, there was ambivalence and even negative attitude towards fundholding but

it was neither universal nor consistent – yet significantly they were in a position of management relative to other partners in their practices. This finding reflects the conclusions of Ennew *et al.* (1998) and Whynes *et al.* (1999) that not all fundholders could be viewed as ‘true entrepreneurs’ although there were clear enthusiasts. However lead partners are not all ‘entrepreneurs’ which has been interpreted as too narrow a view but they may be guardians, opportunists or reluctant innovators in going fundholding as lead partner. The emerging question is what happens beyond that point. How is the management role enacted? There was more to discover.

One of the clear influencing factors in the way fundholding evolved may be the personalities of some of those taking on the lead partner role. The Audit Commission (1996) found that practices differ dramatically in the extent to which they threw themselves into the fundholding initiative, that is, how things were enacted beyond implementation. Studies did not investigate how the lead partner enacted the role: what they did and how they did beyond the ‘going’. The case studies show that there are instances where there is an enthusiastic individual carrying fundholding and, in contrast, those reluctant volunteers that having being assigned the task cannot muster enthusiasm for the role itself. There may also be differing degrees to which these necessary ‘volunteers’ fulfil their role to the full, immersing themselves in the role of managing or treating it as an administrative burden and nothing more. Thus fundholdings’ documented and researched impact goes beyond primary health care management and practices as organizations. The evidence from the case studies suggests there is some meaning for the doctors themselves and consequently there may be things to discover about the way the doctors get involved in management and how their careers evolves as a consequence.

#### **4.7.1 A Role in Management**

The evidence in this study presents the case for moving away from an organizational perspective on policy application and paying attention to the professionals, the GPs themselves. It becomes apparent that GPs themselves warranted more attention because of what fundholding enabled them to do. The data needs to be further interrogated to see how those lead partners enacted the role of lead partner. GPs in the

management role will be faced with more choices – new initiatives, constraints, pressures and opportunities. One choice is taking an *active* lead partner role, a management role in addition to the professional role.

Initial appraisals of fundholding, in the quasi-market setting of the NHS took a somewhat simplistic view that for GPs fundholding released the inner entrepreneur (Ennew *et al.*, 1998; Whynes *et al.*, 1999) and at least facilitated innovative ways to save costs and new ways of working (Lapsley *et al.*, 1997). This research indicates there are factors at play that engage GPs in management roles and to behave in a managerial way. The lead partners are volunteering for a significant role that takes them away from the ‘day job’ and changes their career, which is an “evolving sequence of a person’s work experience over time,” (Arthur *et al.*, 1989). Fundholding was the first major opportunity to move away from the surgery desk into a managerial role and to do so legitimately (funded and with partnership approval) for the good of the practice, frequently under the assumption that it would improve some aspect of patient services and be consistent with the functionality of the professional. It was a justified role for doctors to manage primary health care without being dictated to, empowering them to influence secondary care as demonstrated by LP<sub>H</sub> :

*I think all general practitioners are now beginning to appreciate that they have an important role to play in the planning of secondary care for their patients. Experience has shown, to be honest, the health authority does not have the knowledge. While they consult on public health, they're not clinicians. They do not know what's going on in the front line, therefore they need our experience.*

The value of the primary care clinician managing the commissioning of health care services was noted by LP<sub>H</sub>, very graphically, that fundholding gave family doctors power over consultants, but although some of the interviewees were fundholding enthusiasts, there was little evidence of a widespread, overt strategic motivation towards a primary care-led NHS. Even if they approved of the notion, it does not seem to be what moved most of them to action in the fundholding era. So what was motivating individual GPs? The shift in power was noted by FM<sub>D</sub>, who also remarked that the larger groupings represented by PCGs would ‘give us more power over the hospitals, an awful lot more power’. However, size also has its disadvantages, and

LP<sub>D</sub> expressed the view that commissioning units should ideally remain small because they give a great deal more flexibility, as in fundholding.

One lesson learned here is that the GP is more than a single entrepreneur as they are in partnership within the organization of a practice. The interviews reveal a complexity that may not be understood by super-imposing traditional explanations such as entrepreneurship and practices emulating small businesses (Cowton and Drake, 2000). It seems there are some other factors at work. One such factor that emerges is that the fundholding team can be derived and formed from differing sources: sometimes the practice manager became the fund manager; sometimes the fund manager was recruited from outside; sometimes the GP continued to take an interest in the accounting through mechanisms that produced reports that he/she could use – sometimes they did not (see table 4.8). All in all, how the lead partner as a doctor gets involved in management appears complex and worthy of empirical study. Stewart (1982) suggests that any identification of the managerial roles adopted by individuals, in this research the case of GPs taking on the role of Lead Partner, can be usefully gleaned from original interview questions whose first intention was not to identify managerial roles and that those questions can be a useful source of interpreting the roles acted out by individuals. Essentially, if you ask managers about their jobs then they will give dissimilar answers for many reasons, “comments on relative role importance may reflect cultural perceptions of the right answers rather than the job itself or the manager’s behaviour,” (Stewart, 1982, p.8). Therefore the emergence from the data of the reasons GP become Lead Partners suggests that it is also important to see how they enact that role. Secondly, Stewart (1982) recognised the importance of flexibility as a key characteristic of managerial jobs, that over generalization was unwise and that any analysis needs to consider “the variations in behaviour and the differences in jobs before attempting to generalise about managerial work” and ultimately that *difference* itself is important. The model purports to be realistic and useful way of thinking about managerial jobs and how managers do them. GPs in this study in the main found themselves in roles with no job description and thus no formal benchmark or idealistic model of management. The important question to investigate is what happened under those circumstances? To do so it will be necessary to consider the literature on doctors in management roles

to move from the study of fundholding as part of NPM reforms to the role of doctors in management. This does not mean that the assumptions made under NPM were inappropriate but rather there are other emergent factors that need studying from a different perspective; there is a shift from accounting and creating order and visibility to accounting contributing to the motion and the lived experience of individuals (Humphrey *et al.*, 1993). This will be addressed in Chapter 6.

#### **4.8 Conclusion**

There are a number of conclusions relative to fundholding, the emerging importance of the lead professional in fundholding and the implications for accounting in the management of fundholding.

In respect of fundholding itself, firstly, previous studies had simplified the reasons for going fundholding by concentrating on early waves, using frameworks such as entrepreneurship to analyse fundholding and over emphasising what could be measured easily e.g. demographics. This study has used more cases and more waves and presented multiple factors for going fundholding, identifying more reasons. It therefore contributes to a better understanding of fundholding as part of NPM in the context of general practice. Secondly, the early wave fundholders exhibited more entrepreneurship than later waves, possibly because they had access to greater financial incentives as later ‘bribes’ for going fundholding diminished over time. Some practices chose fundholding in order to protect the practice and avoid undesirable consequences of not being fundholders rather than because of a predilection for it. Consequently, the entrepreneurship model used to consider fundholding, and engagement of professionals, may have been more suited to early wave research of this and similar schemes. A more inductive approach of multiple case studies has revealed the complexities that engage professionals in changes in organisations, not least the important of the context of the organisation and the profession.

In respect of the lead partner, the lead professional, most significantly emerges as a major factor in going fundholding and acknowledging that factor in the interpretation

of fundholding makes for more trustworthy research. Fundholding was unlike other NPM experiments because of the GP; as advocate of the patient; traditionally seeking to retain the functionality of professional arrangements; taking advantage and occupational control by improving conditions of working; and, taking advantage of potential to increase professional autonomy. Lead partners have been categorised as guardians, opportunists, or reluctant innovators having chosen to engage in the lead partner role. Further, the degree to which they engaged once the scheme is live varies. This links with the implications of accounting as how they engage with it and its outputs and is an indicator of what they do and how they execute their lead partner role and warrants further investigation. Further there are early indications that GPs may influence and be influenced by the relationship with the fund manager in what they do and how they do it.

In respect of accounting, per se it does not loom large although it is instrumental to the design of fundholding and what it sought to achieve. The examination of accounting as part of fundholding has given insights into its contribution as part of an accounting change, what its presence enabled, and gives visibility for governance and control by lead partners. Lead partners do not get involved in the mechanics and measurement but accounting did have a bearing in the initial analysis of what they did once they had gone fundholding. Therefore accounting seems implicated in the construction of social order rather than intrinsically important or needing to be understood for its reported dysfunctional consequences.

Studies have paid little attention to what the lead partner does once fundholding is 'live' and it requires exposition. This study contributes to the literature by incorporating the social element of the lead partner and while accounting per se is not important it has implications for accounting change. Hence this chapter has described why practices went fundholding, why the lead partner took on that role and implications of accounting. It makes a contribution to our developing understanding of the fundholding 'episode' in the NHS, but it also goes a stage further by raising several issues. It is time to pay attention to the GPs and their role in management.

## **Chapter 5**

### **Doctors in Management**

#### **5.1 Introduction**

The purpose of this chapter is to review the literature about doctors in management to inform a further set of research questions: How did the lead partner enact the management role; what did they do; and how did they do it? The adoption of management roles by doctors grew as a research topic in secondary care from the mid 1990s but there was little development in the primary care sector. The literature developed most significantly after the conclusion of phase one of this study, and publication of those results, and its development presents the case for considering emergent research questions to interpret the significance role of the lead partner once fundholding is 'live' as a doctor in management. It justifies a second analysis of phase one data in the context of doctors in management, getting involved in governance and control of the organisation in order to add to the literature. Prior to 2000 there was little empirical evidence observing the phenomenon of doctors engaging in management. The literature enables this study to transcend the fundholding moment. Although the opportunities for doctors in primary care to volunteer for management roles were reduced after fundholding ended the policy of engaging doctors in management has returned in primary care, and continued in secondary care, as part of government strategy for the management of the NHS.

This chapter is a literature review of empirical studies of doctors in management in both the hospital and primary care setting. The first section explains how the literature review was conducted and summarised (see Appendix 3). The second section critically evaluates the literature in secondary care, the hospital setting, followed by a third section in the general practice. The two settings are compared and the gaps in the literature identified to inform the questions to be asked of phase one data and to design a second phase of data collection. Like the doctors themselves this thesis takes a managerial turn born of accounting led change in the form of fundholding. Phase

one evidence revealed that GPs who ‘chose’ to take the lead are unlikely to represent a group of likeminded partners. Other partners do not always take a supportive role. It seems GPs can be a difficult bunch! Thus taking the lead was a potentially challenging role for a professional *if* they chose to be active. It added to a personal career domain by taking a lead role in parallel to the demands of a primary profession. With varying levels of enthusiasm those who adopted the role were seen to vary from enthusiastic to unenthusiastic about becoming lead partner. These ‘leads’ were not a ‘skewed group’ of doctors as reported by Fitzgerald, (1994), but might be interpreted as a ‘type’: guardian; reluctant innovator; opportunist, but how did they operate *in* management?

### **5.1 Doctors in Management**

In Chapter 2, through the short contextual history, it is apparent that the place for GPs in the Griffiths (1983) vision for a performance managed NHS was for general management at all levels with an implicit assumption that doctors who did choose to be involved would be natural managers (Buchan *et al.*, 1997). Clinical general managers were thought to have a “better chance of curbing the power of the medical profession but it was hoped clinicians, especially doctors, would take up, general management posts” (Dopson 2009, p.40). This implied that clinicians in resource management would manage the NHS resource better; it would be politically correct for them to be involved as part of the functionality of their professional arrangement that is to maintain patient trust and be the advocate for the uninformed. It also assumed that should doctors choose a management role that they would be active and good managers. At this stage of development in the NHS there was no question of all doctors being forced into management roles.

The literature of empirical studies of doctors in management is summarised (Appendix 3). The table shows the author, date, title of the research, the key themes and findings. The third column shows the country and organisation setting for the research. The fourth and fifth columns show the method used to collect the data and the sample size. The final column elaborates on the title of each paper, drawing out key themes and findings. The criterion for the literature review was empirical studies

of doctors in management. It excluded commentary papers included in the British Medical Journal (BMJ) on the grounds they were not based on observation of doctors in management. Some discussion papers and historical reviews that were not empirical were incorporated where they support and add value to the discussion of the empirical studies and tend to be early in the chronology. The literature does not include other medical professionals who were engaging in management as a result of the reforms, for example, Bolton (1995) studied nurses. The tabulation does not include the literature, for example, relative to the GP contract and fundholding, already documented in Chapter 2. The literature does include studies in secondary care, since that is where doctors were first experiencing management roles.

The aim of this literature survey was:

- to summarise the developing phenomena of doctors in management experienced by those engaging in it;
- to identify if doctors engaged in management, why did they and how?
- to identify if there was evidence of doctors in management in primary care and if so why did they engage in management and how;
- to compare the literature on doctors in management in secondary and primary care to establish similarities and differences.

The literature review revealed other ‘pockets’ of literature which are judged to be on the periphery of the debate on doctors engaging in management. Those broader categories (i to iii below) are not incorporated into the table as a feature of doctors in management because the themes of those studies, while providing evidence and context for doctors in management, were not central to the individual doctors in management debate and were broadly concerned with why doctors as a profession do and do not engage in management. Indeed these themes from the literature on doctors working lives may hinder the exploratory nature of the secondary analysis with pre-conceived notions by focusing on negatives (like many fundholding studies) rather than the positive connotation from phase one of this research about why doctors got involved in management roles. Those three established themes that are omitted from this literature review of doctors in management can be categorized as follows:

**(i) Doctors operating across organisational boundaries and engaging with those organisations.** Such studies concentrated on the practice as an organisation rather than professionals, for example, Currie and Suhomlinova (2006) investigating the extent of knowledge sharing and power differentials in the NHS based in medical centres attached to higher education institutes. The thesis at this stage is seeking to make sense of individual professional roles in management rather than attached to organisations.

**(ii) Relationships between doctors *and* managers rather than doctors *as* managers - their engagement and activity in management:** Studies such as a literature review by Bruce and Hill (1994) concluded generally that doctors are 'lukewarm' about management. Rundall *et al.*'s. (2004) comparative study looking at the strained relationships between doctor and managers in hospitals rather than doctors as managers and recommended doctors should become more involved in decision making especially resource related decision. However, Neogy and Kirkpatrick (2009), for example, more recently looked at engaging professionals in the management agenda rather than management itself to overcome the 'them and us'/doctors versus managers and are incorporated in the tabulation (Appendix 3).

**(iii) Debates solely about profession and power in the NHS.** These include studies such as Ong (1999) and later Russell *et al.* (2010) who concluded that medical professions associated roles in management with powerlessness and lack of respect. These studies inform any debate about doctors in management as a profession and justify the contextual analysis of GPs in the NHS. Such a literature would be more pertinent to the study of doctors who chose not to be lead partners or clinicians in management role. However, although worth a mention here, the GPs in this study do not appear to suffer from perceptions of powerlessness and lack of respect, therefore contributing to the literature. As volunteers in one of the three groups they have sought a management role, even if, in one case it appears no more than nomenclature. More recent comparative studies suggest that in the hospital sector the accommodation between management and medicine and degree of enthusiasm can be nation- specific (Kirkpatrick *et al.*, 2009) but change and reform a consistent factor between nations. These perceived tensions between medicine and management have, directly or indirectly, been the subject of a number of studies carried out since the

mid-1990s (Ong, 1998), and several possible reasons for the tensions between the two have been identified. The power and autonomy debate is founded in the historical position of GPs relative to hospital doctors (see Chapter 2). While it may inform the debate these categories and debates above can be contrasted to the three themes emerging from the NPM literature (Morris and Farrell, 2003). They recognized that the NPM literature had brought forward debate about professionals: in the **interaction and tensions between professionals and managers** (not professionals in a management role) as professions strove to retain autonomy; “that **managers themselves are imbued with managerialism** and have bought into the ideology of NPM” (p.137); that there are ‘**winners**’ and ‘**losers**’ under NPM. Morris and Farrell (2003) criticized the literature for using the crude measure of the pursuit of personal autonomy; perhaps suggesting research focused too much on power relationships and is therefore under developed and biased. Indeed the research in this study indicates that GPs were selecting a role in management in a broader context than simply seeking or retaining personal autonomy which according to Harrison and Pollitt (1994) may well be an illusion. Further, Morris and Farrell (2003) were critical of the conclusion that holding a budget made GPs a winner in the battle for personal autonomy as their own study found that it “assumes that such professionals are desirous of such autonomy, a contentious assumption,” (p.138). All of these studies contribute to the debate on engaging doctors as a profession in management providing background but do not consider managers who have chosen it and what they did in that role and how they did it. The focus was not on those living the management role experience. Therefore the literature review focuses on doctors *in* management at a unique point in time as relative to lead partners in fundholding – a period of precedence of doctors in management that had not been studied in such a context perhaps because of the focus on three themes outlined here.

It seems that the tendency to measure what is easily measured, or readily compared to the private sector, such as entrepreneurship, and the ‘simpler’ debate of the battle for autonomy - can bring pre-conceived ideas, thus suppressing emerging and richer debates. This study of doctors in management presents a new approach and strategy for analysing doctors in management which acknowledges the context of other debates in the literature but is not constrained by them. Where studies from primary

and secondary care are useful to the doctors in management context and do contribute to the doctors in management literature they have been incorporated into the table in order to give focus to this under explored area to assist in a secondary analysis of phase one data.

## **5. 2 Doctors in Management: at the hospital**

This section identifies the literature on doctors in management and its beginnings in the hospital setting. It identifies themes, findings and recommendations.

### **5.2.1 Reluctance to Engage in Management**

The attempt to engage health professionals in managing, or with the management of, the NHS has been brought about through successive policies targeted at different professions within the NHS. Hospital doctors were targeted before GPs. Bolton, (2005) argued that when professions are perceived as difficult to manage the solution has been to create managers from the profession requiring managing. These professionals as managers may inform future efforts at engaging professionals with management within the same setting such as the NHS (Kitchener, 2000), and future reforms. Perhaps rather than having management done to them by professional managers the professionals in their primary domain, their first profession, will be better at doing it, perhaps better at doing it to their peers, and possibly more accepted by the peer group than a professional manager. Consequently those professionals in healthcare may be better managed as a whole if managed by the peer group. The implications for the NHS are a more resource effective, efficient and hence economic NHS.

As health reforms were rolled out, some doctors took management roles. Early research in secondary care indicates that doctors did not take well to management (Hunter, 1992; Buchanan *et al.*, 1997), some exhibited a reluctance to accepting management roles (Brazell, 1987), some even describing it not as a cure but as a ‘disease’ (Dopson, 1994; 1996). Doctors have continued to dislike management; Witman *et al.* (2010) reported reluctance and Russell *et al.* (2010) negativity arising

from a perceived lack of respect of doctors in management roles. Gatrell and White (1996) thought “many doctors employed in the NHS regarded ‘management’ as an alien process, which acts to the detriment of good health care”, (p.6) whilst others embraced the notion (Walker and Morgan, 1996).

Fitzgerald (1994) recognised that not all doctors were averse to or reluctantly engaged in management and categorized reasons for adopting management roles in secondary care identifying three dimensions that drew doctors into management in secondary care: making assessments and judgments about the changes in health care; attraction of a part-time role rather than giving up primary profession; the challenge of management. The multiple factors of changing health care, attraction of multi –career and seeking a challenge suggest there may be political interest, a personal career choice and elimination of ennui involved and that these may have not been mutually exclusive. Certainly, the data analysis from phase one concurs that doctors going into a management role in primary care do so for multiple reasons and the activities and levels that they operate at once they are in that role may vary. The evidence from Chapter 4 in primary care is consistent with Fitzgerald’s (1994) conclusion that not all doctors are reluctant to be involved in management. However, few studies have examined that aspect of doctors in management.

### **5.2.2 Curing Reluctance with Education**

One of the early themes emerging from the literature is that educating doctors in business and management (Newman and Cowling, 1993) would increase the confidence of doctors who were involved in management and with managers. The suggestion that doctors need educating in management is incongruent with Griffith’s assumption that doctors are natural and therefore appropriate managers. However, education by management development was prescribed in order to make doctors better managers (Newman and Cowling, 1993; 1994: Allen, 1995; Owen and Phillips, 2000) regardless of the increasing evidence that most doctors just did not wish to be managers. Mark (1994) concurred with the idea of management training for doctors even if at the very least it merely identified those doctors that did not want to be a doctor also involved in management alongside the primary professional career.

Prior to a study by Buchanan *et al.* (1997) most of the studies of doctors in management concentrated on getting doctors involved in management and resolved with a 'deficit' model, linked to a deficient skill set in management by doctors (Mark, 1991). There are strong indications in the empirical literature that doctors were not keen on management and also lacked management skills. Perhaps education in management might encourage them into management and may increase the possibility of turning a specialist/professional into a generalist in the art of management. This seems to suggest that education would be the easy way to excite doctors about management, as if there was a fear of, or incapability, to execute management. Leopold *et al.*, (1996) debated the role of general manager as opposed to a specialized professional – if professionals cannot be encourage into management then put a general manager in place. With that scenario, given that existing research reports on tension between doctors and managers then alongside power play it seems doctors may be forced into management roles when faced with a general manger being the alternative.

### **5.2.3 Doing Management in Secondary Care: How?**

Of the few empirical studies of doctors in management there was frustration (Dopson, 1996) that the debate at a conceptual level meant that there was little work “exploring the doctors’ role in the management of health services and even less work has been done exploring the implications of recent moves to involve doctors more closely in the management process” (p.173). There was much about *attempting to* engage doctors in management in secondary care *and why doctors did not* but not a lot on what they did when they were in that role. Dopson (1996) recognized modelling doctors on general management roles for the management of secondary care was problematic arguing that researchers needed to look at career interest, “...unless more empirical work is done looking at the complexity of the issues surrounding doctors in management roles, then the debate is unlikely to get beyond definition mongering” (p.186). Career interest was also a consideration in other studies in secondary care (Mark, 1991; Gattrell and White, 1996).

Crucially the doctors in management literature shifted beyond the normative for doctors in management, from what it ought to be like to how it was being done in secondary care. Buchanan *et al.* (1997) considered *how* doctors were engaging in the management process in secondary care and the evidence for how they fared in that role. The empirical findings of the study are summarised in Table 5.1 categorised as a good indicator of the issues that arise when doctors engage in management and are notable for continuing negativity when actually in the role. Though the elements in the table are consistent with Fitzgerald’s (1994) evidence of being involved in assessment and judgment of healthcare and problem solving, challenge and enthusiasm are not apparent.

The doctors in management literature in secondary care had shifted from reflections on policy, what that management ought to be like and how the rationale of the policy might be achieved through education to the start of how management was conducted. First and foremost it identifies the doctor in management as reluctant and resolution by education in general management. Therefore the approach to resolving the problem of getting doctors involved in management was focussed on the deficit model, perhaps in the absence of success in getting doctors to volunteer in secondary care.

<b>Evidence</b>
<b>Tensions</b> develop between professionally representing colleagues and managing colleagues. Tensions arise when those engaged in management override colleagues.
<b>Defensive engagement:</b> doctors engage with no sense of purpose or ambition for management.
<b>Lack of clear definition of the role</b> and lack of management training.
Management as a necessary <b>burden</b> ; a position to be handed on at available opportunities rather than sustaining the individual in management.
<b>Influence on the hospital management</b> process was limited for hospital managers
<b>Satisfier elements:</b> access to information; problem solving; contribution to service development
<b>Key elements of dissatisfaction:</b> unrealistic targets; paperwork; time pressures
<b>Advice to others:</b> Don’t do it; understand the time pressure; have prior management training; delegate; get good support; establish voice on hospital board

**Table 5.1 Doctors Engaging in Management the Evidence from Secondary Care**  
**Source: Buchanan *et al.* (1997)**

This in turn means there was a lack of individuals to study and, of those in management, they might not wish to appear to have the 'disease', hence few studies of how they act in those management roles. It suggests that the gap in understanding getting doctors involved in management is because the focus is on general management principles applied to doctors rather than studying those who do it, what happens when they do it, how they do it and consideration of the implications of those who have engaged in management.

#### **5.2.4 Reluctant Manager to Roles for Hybrid Managers in Healthcare**

The next stage in the doctors in management of secondary care literature paid more attention to how the manager role developed for those committing to it. Power struggles in the NHS featured in this tranche of research. Before Griffiths (1994) managers - or 'administrators' - were traditionally viewed as being responsible for 'sorting things out' without impinging upon doctors' clinical freedom (Brazell, 1987). The promotion of management as a feature of the NHS threatened to establish a rival professional group with a different set of values and assumptions (Willcocks, 1998). If the doctors weren't taking to management then they would be managed by general managers as management was embedded as part of the future of the NHS. As Hunter (1994, p.1) commented, a 'principal feature of the evolution of management in the National Health Service (NHS) has been the struggle between doctors and managers for control of the health policy agenda and its implications for resource allocation' and now the new enemy appeared to be managers. However, first analysis of phase one data does not show a predominance of: comments on power struggles with consultants and the secondary care sector as a significant reason for going fundholding; tensions between fund manager and lead partner. The absence of a doctor versus manager conflict in phase one analysis can to some extent be explained by the fact that fundholding was voluntary. Also lead partners appointed their fund managers from within or outside the practice and the person was not imposed on them.

Studies were published in secondary care (Fitzgerald and Ferlie; 2000: Kitchener, 2000) that examined the notion of the hybrid manager as doctors took on management

roles. At last, attention turned away from what management ought to look like for doctors and moved on from the education of professionals in management. Fitzgerald and Ferlie (2000) studied the impact of the internal market on power and autonomy issues and the creation of a hybrid manager but focused on negative issues for getting involved in management. Kitchener (2000) addressed the professional role change in secondary care and possible de-professionalisation of doctors from the main professional domain through involvement in management.

Prima facie, a hybrid manager was a description for a role, a research approach criticised by Dopson (1996) because the emerging descriptive empirical data did not identify what that role might be like: what did these managers do and how did they do it? This suggests that research may still have been focussed on the policy agenda of the profession rather than the evidence of doctors in management. Nevertheless, this new professional group, described as hybrid managers continued to be reported as reluctant – there was a persistent aura of negativity about the doctors in management in a secondary care setting:

*Involvement is a way of preventing an erosion of discretion by professional managers. "Fear of being managed" by others is thus a key motivator. Doctors are not comfortable with the notion of decisions affecting patient care being taken by non-medically trained personnel. A hospital consultant may remain in the same job for 25 years; a move into management post may offer additional challenge and variety, even if it is temporary. (Buchanan et al., 1997 p.133)*

Mark (1991) argued that whilst ever doctors in secondary care are questioning what is in it for them in by getting involved in management, there is an error in an assumed 'willingness' by those adopting the role. The doctors aren't choosing management at all but are getting involved for other reasons. Rather like Griffith's misconception of 'natural managers' there is a problem. It seems there was not enough empirical evidence to explain the factors contributing to why doctors got involved in management. Even with the description of a hybrid manager the evidence of what they did and how was lacking. This gap in understanding may arise from pre-conceived ideas and assumptions about the importance of the fight for autonomy and power within the NHS and all of the assumptions about not wanting to be in that

position. Similarly faced with a description of a hybrid manager role, Fitzgerald and Ferlie (2000) appear to assume that it is an active management role rather than passive, a title designate. If they are reluctant managers, what do they actually do in the name of management?

Marks (1991) is the only author to consider the lack of research and attach importance of the doctors' (in primary and secondary care) individual needs and choices in management. This was surprisingly early on in the doctors and management literature but has not been taken forward conceptually as part of the research agenda. One wonders what may have caused such an oversight and if it is a more important factor than the literature suggests. Perhaps there is some indication of the reason for this oversight in the peripheral literature noted earlier in this chapter which focuses on boundaries, relationships and power rather than the individual pursuing their own career. Nevertheless, one way in which the literature does consider the individual is their personal role as a hybrid manager which may or not be shaped by the boundaries, relationships and power struggles surrounding a foray of clinician into management. Therefore this section has introduced the concept of the hybrid manager, the hybrid doctor in management. It is merely a concept. The next section expands the literature beyond describing the existence of a hybrid manager to examine how the role was enacted.

### **5.2.5 Managers and Roles: Hybridisation, Polarisation and Accounting**

Doctors were described as hybrid managers in some of the literature because they did not relinquish the primary professional role. Fitzgerald and Ferlie (2000) and Kitchener (2000) also reported a preference for part-time roles. Thus the evidence shows that those in management keep the original specialised role and that education in management to create an enthusiasm for a management role was the remedy to getting doctors into management roles. Later, Jacobs (2005) found that management education in the curricula may not always be successful in creating hybrid managers, suggesting that the level of hybridisation depends on other actors that is, what people around the doctor-manager do. That supports Dopson's (1996) suggestion that

researchers need to confront different people and groups to understand more about doctors in management rather than only doctors themselves.

Indeed the study by Jacobs (2005) takes the literature of doctors in management and hybrid roles to consider accounting as one of the mechanism that supports the role of doctor in management, as part of accountable management reforms. Accounting gave visibility in the organisation touched by NPM creating a domain of economic activity, capturing data for decision making. Thus after phase one of this study, researchers began to consider the role and involvement of accounting and linking it to management activity. The studies contend that accounting and its use by players in argument was an indicator of the profession getting involved in some job activity that involved management – a form of hybridisation. Kurunmaki (2004) had found that the intrusion of accounting practices in Finland in the context of the medical profession based in hospitals was successful. She examined the calculative practices of managerial accounting in the context of Finnish NPM reforms. Doctors accepted accounting practice as part of their hybrid role demonstrated by financial argumentation (i.e. a capability to talk about the ‘financials’ to support decisions in management). Therefore how that role was executed as a manager involved use of accounting. However the study recognized that the growth in financial knowledge and capability by the hospital doctors was largely due to the lack of a formalised accounting profession to defend their domain in the hospital setting (unlike the UK where accountants were frequently in management roles) and the incorporation of financial knowledge into the curricula for the doctors. Therefore when Jacobs (2005) extended the Kurunmaki study to Germany, Italy and the UK it was found that accounting did not feature in playing out the hybrid manager role because others were taking care of the ‘financials’. Rather, the medical managers (not doctors) absorbed the accounting and financial argumentation to such an extent that she used the term polarization to contrast to the term hybridization of medical and management roles. Doctors were not becoming hybrid managers because medical managers, similar to the post of fund manager in fundholding, were taking those roles.

In this study, phase one analysis in primary care shows accounting clearly not to be important per se for GPs in their new found management role: they were not taught about it; they did not have an interest in it. Accounting did not feature significantly as part of their entrance into the management role but it did facilitate some of their sustained management actions beyond going fundholding (See Table 4.8). In the context of Jacobs' work logically if accounting is fundamental to fundholding and its management then the findings in this study would indicate polarization because of the fundholding manager role, that is, accounting and its associated financial argumentation might be absorbed by the fund manager. This then raises the question of what was the GP as lead partner doing and how were they doing it? How were the lead partners engaging in management if they sustained the role beyond actually going fundholding? Was the significance of GPs in management in primary care also characterized by hybridization or polarization?

The Jacobs (2005) study added to the debate by conceptualising the potential for different levels of hybridization because she defined hybridization as “deep and fundamental change such as the offspring of two animals, plants or species and a lasting change to the DNA of these species” (p. 135) and she presented the concept of polarization as an alternative being “the separation of a group into sub-elements on the basis of class, gender, or some other characteristics”. The former terminology is taken from the natural world and the second from social analysis. Polarization may be apparent as non-medical professionals are a feature of the NHS such as hospital administrators and managers in secondary care and practice managers in primary care who are conducting the management activity. Thus are we in fact looking at different levels of hybridization with the extreme being polarisation? Can the types of doctor as manager help us identify the real roles that doctors take on as managers and/or help the analysis? Can what doctors do and how they do it present different levels of hybridization? These emergent questions arise and support the case for re-analysis of the phase one data based on the post-phase one development of the literature of doctors in management in secondary care.

Ostergren (2009) did take Jacobs' (2005) classification forward and decided that Llewellyn's (2001) study of hospital doctors indicated hybridization rather than polarization. However although the earlier study, relative to Jacob's (2005) study, had the primary role of looking at the medical-management interface the results can also be argued here to suggest polarization and hence contradicts Ostergren (2009). The 2001 study had sought to understand the aspirations and activities of doctors with management responsibility in the context of the 'new' area of expertise of medical-management using the metaphor of a 'two-way window'. Although it recognized the notion/concept of a hybrid professional it also identified that, firstly, when professionals held budgets but lacked expertise (to control information on which budgets are founded and to interpret their messages) they were able to 'devolve financial responsibility' without transferring financial control. Indeed it is contended here that Ostergren (2009) may be incorrect to assume that devolving responsibility means less potential for hybridization towards a management role. This is because Ostergren's (2009) argument focused on the proximity of accounting to the management role rather than accounting change. Perhaps hybridization should be construed as a feature based on what is done with the information that comes back from those that the data is delegated to. Indeed that change to the makeup of the doctors in management role could be hybridization as it depend on how doctors engage. It is not about what they do with the accounting itself but how it engages them in the end itself that accounting change creates. Accounting and budgets become a means to an end for the doctors in a management role and therefore a feature of levels of hybridisation.

Llewellyn (2001) also identified that doctors may risk losing clinical visibility and respect and will therefore present the management tasks as supplementary thus avoiding crossing the divide into the domain of management. No studies have addressed, in any depth, what they do and how they do it through the lived experience to corroborate it or dismiss the representation of it being supplementary. Doctors may say one thing but do another. The presentation of management as supplementary may be a façade - a way for doctors who like management to hide their guilty secret of being involved and enjoying management. The way they engage may be presented as supplementary but it is important to investigate the way management is acted out by

clinicians once they have chosen to be involved in it. One wonders if the allocation of doctors to either position is unhelpful because too much attention is paid to the process by which accounting and/or management occurs, that is what is done, rather than how it is done. This suggests that studies should look at the human actions of the actors within a profession rather than the process, that is how they go about doing what they do, rather than what they do. Tasks may be presented as supplementary but how do they engage? This is particularly important in a profession as professionals work within their organisation and often beyond the boundary, representing the practice, as in the lead partner role, and suggests that Marks (1991) concept of the *individual* needs and choices should be revisited in order to understand the doctor in management. Can that engagement in management be more than bureaucratic (Kitchener, 2000) and represent more than the concept of an option of a hybrid role? This section has introduced the debate of hybridization/ polarisation for doctors in management in secondary care and therefore suggests the need to consider the implications of phase one of the research for developing a better understanding of doctors in management and degree of engagement.

#### **5.2.6 Hybrid Managers: Volunteering for Management for Negative Reasons**

In secondary care the establishment of clinical directorates had both decentralised management and meant that clinicians can continue in their speciality while carrying out a management role (Fitzgerald, 1994) though they may be hostile to that role (Cavenagh, 2003). Dopson and Fitzgerald (2006) continued to refer to clinicians in the acute sector and general practitioners as hybrid managers in a middle manager's role. Although such posts were found to be more attractive than full-time management responsibilities, as Buchanan *et al.* (1997) remark, it is striking how many of the reported reasons for taking on a management role tend to be negative or defensive, with little sense of doctors becoming engaged with a sense of purpose or ambition, unlike some of the GPs in the period of fundholding in this study who were evidently more enthusiastic. For example, Dopson (1994) reports that the most frequently mentioned reason was the fear of being managed, that is, suffering as a consequence of being managed by another. Most consultants 'are reluctant managers' (Dopson, 1996, p.185). This negative view tended to be confirmed by Buchanan *et al.*'s (1997) own fieldwork. Of six clinical directors interviewed, five said that some form of

pressure, from colleagues or the chief executive, had persuaded them to serve. They were not positions which had been sought with enthusiasm, and the clinicians wanted to return to their medical specialty. A desire to return suggest that once involved in management it did not become embedded in the professional life of the clinician and just as they had ‘chosen’ to opt in they also chose to opt out. This suggests that the hybrid manager role, whatever it may look like, for many, may have been a transient or temporary role. The role may be transient in that it leads to a move into something else. Few studies provide the opportunity to see the impact of the experience of being involved in management as a doctor on the longer term careers and activities of doctors and the subsequent choices they make through a second phase. Thus, the literature in this section suggests that reluctant hybrid managers breeds transient hybrid managers and the research does not address if it is regressive (away from management) or progressive (further into management).

Thus the evidence from secondary care has been considered and the notion of a hybrid manager (Fitzgerald and Ferlie, 2000; Kitchener, 2000; Dopson and Fitzgerald, 2006) is explored and extended through Jacobs (2005) study. In secondary care: doctors dislike management; are reluctant to engage in management; view management as an alien process; may consider management as detrimental to good health care; are seen to be hybrid managers in a narrow sense of the definition; are attributed to involvement in management by involvement in accounting and financial argumentation; doctors seek to delegate management; doctors seek to polarize management from doctoring; doctors who engage are satisfied by access to information, problem solving and ability to develop services; doctors do not choose to continue a career in management.

### **5.3 Doctors in Management: in Primary Care**

#### **5.3.1 A Different Starting Point**

Traditionally, GPs could choose a role in management within the scope of their profession through being a ‘senior partner’ heading up a partnership. However, the designation of ‘senior partner’ was usually titular, for example as witnessed in Practice A, D and F, arising from seniority and did not necessarily mean active

engagement in a management role. Practice managers were appointed for the management and administrative burden of running the practice. There were no management guidelines nor a prescription of what the fundholding practice should look like and therefore not only was there choice in whether to go and decisions about the role of lead partner but there was choice in how fundholding would be manifested in the management of the practice. Consequently GPs within a partnership could choose a lead partner role.

The literature in Appendix 3 shows commonality between primary and secondary care in the widespread reluctance for GPs to be involved in management before (Greenfield and Nayak, 1996; Cowton and Drake, 1999) and during fundholding (Table 5.4). Few could predict how getting involved in the management in primary care would work and who would be involved as the capability to be fundholders was determined by administrative and IT capability (Newton *et al.*, 1993). Further, Newton *et al.* (1993), found that in the process of fundholding the practice management structures did not change and decision making remained the domain of the doctors. Thus, early indications were that management of the business environment in primary care differs from the secondary care setting and management roles already existed. It seems that fundholding may not alter the status quo of managing a practice and doctors 'doctoring' given existing management structures. In the context of hybridization and polarization (Jacobs, 2005) the management and administrative role could be polarized by the employment and work given to a practice manager. Despite fundholding involving choice in being lead partner there was still reluctance (Cowton and Drake, 1999a) just like secondary care.

The fundholding period did not make much of an impact in the literature of doctors in management but it did at least start the consideration of doctors in management beyond secondary care (Newton *et al.*, 1993, Greenfield and Nayak, 1996; Llewellyn and Grant, 1996; Cowton and Drake, 1999a; 1999b). Table 5.2 shows a short time period of fundholding studies within the overall literature. While the doctors in management literature itself begins in 1987 the first study in the GP context came in 1993 based on fundholding, two years after the scheme began in 1991. The demise of the scheme came when approvals for fundholding ceased in 1997 and it ended in 1999.

The Goldie and Sheffield (2001) study was based on the follow up to fundholding, GP commissioning, finding little managerial domain for GPs and continued reluctance with fundholders missing fundholding. The Morrison and Farrell (2003) study returned to NPM for its theoretical foundation with a broad perspective on schools, social workers and GPs therefore did not consider doctors in management roles specifically. Therefore, as concluded from the literature in Chapter 2 and the analysis in Chapter 4 there has been very little published empirical research in the context of GPs as doctors in management. Goldie and Sheffield (2001) demonstrated that the benefits of fundholding for GPs getting involved in management and commissioning did continue as new policies emerged. That study also stands out as one of the very few studies that did consider the future research implications of doctors in management initiatives as identified by Dopson (1996); GPs were desirous of collaboration arising from the initiatives but did not wish to manage their peers.

<b>Year</b>	<b>Author</b>
1993	Newton <i>et al.</i>
1994	Gattrell and White Greenfield and Nayak Llewellyn and Grant
1999	Cowton and Drake
2001	Goldie and Sheffield
2003	Morrison and Farrell

**Table 5.2 Incidence of GPs in Primary Care as the Subject in the Doctors in Management literature**

Whilst one study returned to NPM foundations (Morris and Farrell, 2003), and part of the sample included GPs, there continued to be much more on hospitals managers (e.g. Kurunmaki, 2004) and more in the context of other countries (e.g. Kirkpatrick et al. 2009) perhaps reflecting research following health reform trends across the globe that involve doctors in management. In the UK as the government, in coalition, is

more Conservative than Liberal Democrat and may well send signals and return to policies based on managerialisation parallel to other professions in the public sector (Warwicker, 1998). However, managerialisation is critiqued as unhelpful terminology as it is rarely defined with precision and “embraces a range of quite different changes” (Fitzgerald and Ferlie, 2000, p.717) but is used here in its widest sense as we begin to explore the involvement of GPs in management.

### **5.3.2 Hybridization or Polarisation: A Gap in the Literature**

GPs are unlike doctors who engaged in management through clinical directorates for a number of reasons. Firstly, they have functioned as part of a partnership and effectively operated as a small business (Cowton and Drake, 2000). Secondly there are sub-groups within GP practices already to whom GPs have historically delegated tasks as indicated by Newton *et al.*, (1993), delegation to fellow GPs and administrative personnel. Some GPs take on leadership of a certain aspect, as part of the functioning of a professional partnership, and also through managing the practice managers. Newton *et al.* (1993) studied three aspects of first wave fundholders: the process of becoming fundholders; changes in practice management; and organisation as a consequence of fundholding. They identified that structures did not change and decision making was by the ‘clinical partners’ in line with continuation of traditional approaches. This early study of fundholding and how the roles were enacted concluded that practice managers were like managing directors and that the GPs, as clinicians, regarded the practice merely as “shared premises, clerical and ancillary services – only as a convenience: a base on and from which they are free to practice their craft”, (p.73). That convenience is consistent with Harrison and Pollitt’s (1994) notion of occupational control seeking congenial working conditions. Further, GPs were not involved in the mechanics of the scheme and there was little organisational disturbance hence little involvement in management. It seems polarization between doctor and manager role was embedded in the organisation of general practice. However, this conflicts with the evidence in this study of the emerging significance of the lead partner and therefore the manager role might become more important in the context of general practice. There is no exploration in the literature of GPs as hybrid managers unlike the literature in secondary care.

### 5.3.3 Contrasting the Experience of Doctors in Management: Primary Care versus Secondary Care

The existing small scale studies in the context of primary care are compared to the findings of Buchanan et al. (1997) in Table 5.3. Newton *et al.* (1993) reported that lead partners who had assumed or been given the role saw little impact on their pre-fundholding role. They retained day to day decision making hence clinical autonomy which implies a polarized hybrid manager. However, it recognized that role of monitoring of clinical activity had to be managed somehow but there was no evidence

<b>Evidence from Buchanan et al. (1997): A study in secondary care</b>	<b>Existing Primary Care Evidence: Summary from the literature Review</b>
<b>Tensions</b> develop between professionally representing colleagues and managing (overriding them).	No evidence but lead GPs worried about it (Newton <i>et al.</i> , 1993). Lead partner practice role did not differ to the pre-fundholding role.
<b>Defensive engagement:</b> no sense of purpose or ambition for management	Common that it was not purposeful engagement Ennew <i>et al.</i> , (1998) and Newton <i>et al.</i> , (1993)
<b>Lack of clear definition of the role and lack of management training</b>	Fundamental characteristic of the implementation of the scheme.
<b>Management as a necessary burden; a position to be handed on</b>	Disgruntled at management role e.g. Greenfield and Nayak (1996). Concept of the 'next mountain' Glennerster <i>et al.</i> , (1993). Some enthusiastic GPs later became more keen on the management role (Cowton and Drake, 1999a)
Influence on the hospital management process was limited	No evidence of driving the other partners decision making process either clinically or managerially.
Satisfier elements: access to information; problem solving; contribution to service development	No analysis or indicators.
Dissatisfier elements: unrealistic targets; paperwork; time pressures	No analysis or indicators.
Advice to other: Don't do it; understand the time pressure; have prior management training; delegate; get good support; establish voice on hospital board	No analysis or indicators.

**Table 5.3 Comparing Primary Care Evidence form the Literature to Secondary Care: early indicators of the impact of doctors involved in management**

from Newton *et al.* (1993) that the lead partner worried about tensions developing between fellow professionals as management roles were acted out *if* they were acted out. Partners said they did not ‘drive’ the other partners in their new found ‘management’ role, “for many clinicians fundholding was an administrative change which no more impinged on their role as doctors than any other administrative change”, (Newton *et al.*,1993, p.72). Therefore the study findings imply that doctors did not enact a management role despite being in that position.

Greenfield and Nayak (1996) reported disgruntled GPs who did not see the use of business and management methods as part of their professional role. The recurrent theme is that doctors were adopting a management role that was defensive and with lack of purpose, even delegated down to junior GPs (Glennerster *et al.*, 1993). However, there is no sensation of what doctors in these roles did, what they delegated and how. The cumulative evidence so far is that with no clear definition of the lead partner role, or how fundholding in the practice might work that it could and did evolve as each practice and or lead partner saw fit therefore there were choices being made by lead partners about what to do and how to do it.

Table 5.3 identifies the gaps in the evidence from primary care compared to secondary care using Buchanan *et al.* (1997) to frame the issues observed in secondary care. There are similarities in the top half of the table (highlighted in bold) but not in the bottom. The empirical evidence does not consider the challenges nor satisfiers and dissatisfiers in primary care although fundholding was an ideal opportunity to examine them. What is clear is that the emphasis on reluctance is mollified with ‘satisfiers’ as the literature considers the actual role doctors take in management compared to broadly reported reluctance in other studies.

Fitzgerald (1994, p.36) observed that the ‘stimulation and interest of a new challenge is a powerful motivator to doctors’; or, as Dopson (1994, p.32) puts it, reporting on her own fieldwork, “about a quarter of the sample admitted they took up the role because they were bored”, consistent with Glennerster *et al.*'s (1993) ‘next mountain’ for fundholders. Willcocks (1998) meanwhile identified some enthusiasts in

### 5.3.4 Primary Versus Secondary Care: Themes Reveal Gaps in the Literature

Observation	Profession 'as a whole'	Secondary Care	Primary Care
Perceived need for role for doctors as managers		Brazell (1987) Dopson (1994) Rundall <i>et al.</i> , (2004)	Newton et al (1993)
Management should have high level of reality for their work i.e. assessment and judgment about healthcare		Brazell (1987) Fitzgerald (1994)	
Some doctors are motivated into management		Fitzgerald (1994)	Llewellyn and Grant (1996) Cowton and Drake (1999a, 199b)
Doctors as reluctant managers		Dopson (1996) Fitzgerald and Ferlie (2000) Doolin (2001) Witman et al (2010)	Greenfield and Nayak (1996) Cowton and Drake (1999a, 199b) Goldie and Sheffield (2001) Morris and Farrell (2003)
Individual development of doctors in management roles through career paths. Engagement in the management encouraged rather than prescribed. No average doctor/manager.	Mark (1991) Gattrell and White (1996)	Dopson (1996)  Buchanan <i>et al.</i> (1997)	Greenfield and Nayak (1996) Llewellyn and Grant (1996)
Educating Doctors in Management is key	Gattrell and White (1996) Owen and Phillips (2000) Clark and Armit (2008)	Mark (1991; 1994) Hunter (1992) Newman and Cowling (1993) Allen (1995)	Allen (1995) Llewellyn and Grant (1996)
Important to look at management in context of role and activity		Fitzgerald (1994)	
Management is preferred as a secondary /part-time role. Notion of hybrid manager role.		Fitzgerald (1994) Dopson (1994) Fitzgerald and Ferlie (2000) Kitchener (2000) Llewellyn (2001) Kurunmaki (2004) Ostergren (2009)	
Management is liked/desired for the challenge – stimulation and interest i.e. relative to primary role		Fitzgerald (1994) Walker and Morgan (1996)	
Doctors missed management when budgets were withdrawn			Goldie and Sheffield (2001)
Clinicians that hold budgets who lack expertise devolve financial responsibility but retain financial control.		Llewellyn (2001) Jacobs (2005)	Hannah et al (2005)

**Table 5.4 Profession, Secondary Care and Primary Care: Themes from the Literature**

secondary care, often from the less 'glamorous' areas of clinical practice, who positively wanted to do management. Management seems like an alternative and therapy to a catalogue of symptoms indicating dissatisfaction and/or boredom. Thus, while the medical profession as a whole may continue to question its role in management, 'individual doctors from the profession may have differing needs and perspectives on what a management post will give them at a personal level' (Mark, 1991, p.7).

However, without guidance on what a management role may involve, being free from a preconceived notion of management then fundholding gave opportunity to observe what they choose to do and how to do it. However, one of the difficulties of this analysis of a small literature is that the methodology in these studies does not lend itself to extracting meaning of individual GPs in management. The focus on practice views rather than GP views was exposed in the initial analysis of phase one data and it appears again here as the individual in the management role is not addressed in any depth.

Table 5.4 summarises key themes from the summary of literature (Appendix 3). It removes some of the peripheral literature to focus on emerging questions of enactment of the role. It demonstrates the gaps in the primary care setting which this study may address some evidence for based on a second analysis of phase one data in order to interpret relative to the evidence from secondary care in order to add to the literature on doctors in management.

#### **5.4 Conclusion**

The doctor in management literature follows trends in health policies and is strongest in secondary care with some studies in primary care because of fundholding. In both settings the doctor in management has a role that is relevant to making assessments and judgments about healthcare. Similarly, both sectors identify doctors as reluctant managers with some evidence that there are enthusiasts. There is little prescription for what a doctor/manager should do when they take up management roles. Studies propose the individual should be developed as a doctor in management alongside management in the curriculum. However, there are choices for the doctor in a management role as not all doctors will take, or see the role, as an opportunity. The

first part of the thesis has identified how doctors in primary care took up lead partner roles. There is a gap in the literature in primary care of how doctors enacted the role once they were in that position. Fundholding and the phase one data can contribute insights through an examination of the enacted management role; what did they do and how did they do it. This chapter has reviewed the doctor in management literature and will inform the secondary analysis of the data in order to identify how the management role is enacted, contributing to a gap in the literature in both secondary and primary care.

## Chapter 6

### GPs in Management: What They Do and How They Do It

#### 6.1 Introduction

This chapter examines how the lead partner enacted the management role to answer the fourth research question: what the lead partner did and how they did it, in order to inform our understanding of doctors in a management role. The chapter returns to the phase one interviews and re-analyses the empirical evidence. The main aim is to interpret how the role was enacted in order to contribute to the doctors in management literature. This focus upon doctors in general practice being involved in management will complement the findings on reasons why practices go fundholding, extends an understanding of the role of accounting in NPM initiatives, and investigates if doctors who choose management as guardians, reluctant innovators or opportunists, are active in that role or a lead partner in name only. The latter is important relative to the literature in both primary and secondary care yet most studies of doctors in management have not investigated a role *in* management though have debated those taking, and why they do not take, management roles - primarily so in the secondary care sector. Further, this study contributes to the literature by looking at doctors in management in primary care to consider the factors that contribute to levels of engagement, where policy has recently re-focused.

The first section of the chapter will present a framework for the analysis of phase one data to identify what the doctors did and how they did it. The second section presents the analysis of the phase one interview data and considers hybridization/ polarisation extending the debate to primary care and the possibility of levels of hybridisation. The third section discusses the implications for doctors in management.

## **6.2 GPs in Management: From Taking a Role to Being Involved**

The study began with practices going fundholding but has found that GPs who took on the lead partner role were a more significant phenomenon as part of the process of the practice going fundholding and that the role of accounting as part of that development was not significant in itself. The development in the doctors in management literature has large gaps that do not present evidence of doctors in management in primary care. Volunteering for fundholding was a lead partner choice, conducted with varying levels of enthusiasm or not (Glynn *et al.*, 1992; Llewellyn and Grant, 1996; Ennew *et al.*, 1998, Cowton and Drake, 1999a; 1999b; 2000). There were indications in both primary and secondary care that a management role did not necessarily gain favour and doctors did not continue in management. Therefore there were further choices about the format and levels of the role –on the one hand it could be borne out as management role and manifest itself with the creation of a hybrid manager or not be enacted at all – a polarisation of the primary and management role, often through a process of delegation. Fundholding is an excellent vehicle for exploring choice by doctors about getting involved in management because it was free from any policy prescriptions or constraints; it was neither compulsory for the practice nor the lead partner and the latter had no guidelines and requirements for management. Further, earlier analysis in the study found that the notions of power and autonomy were not that significant in taking a lead partner role – rather a multitude of factors beyond traditional notions of doctors in management. Now this study has contributed to why doctors in primary care get involved in management it can be taken to the next stage. Therefore research question four asks how did the lead partner enact the management role; what did they do and how did they do it – how did the doctor engage?

### **6.2.1 What Did Lead Partners State their Role Was?**

The lead partners in phase one had been asked what was their role in fundholding and these are documented in Table 6.1. The length, detail and nature of the response were varied. There was a great deal of variety across the twelve practices about what the roles was involving deferral to the fund manager (LP<sub>B</sub>) and the practice as a

partnership, for example, LP<sub>A</sub>, LP<sub>I</sub>, LP<sub>L</sub>– so what were these lead partners actually doing *in* management?

Lead Partner	Class	Direct question: What is your role?
A	<b>Guardian</b>	“...what our activity was, ensuring contracts that look after patients and not take too many risks...extension of role of lead partner in city GP fundholding organisation”.
B	<b>Reluctant Innovator</b>	Refers to fund manager ... “keen to be fairly aggressive, the accountancy background, get the money right, get the contracts right...”
D	<b>Guardian</b>	“As an advisor to the partnership on the financial and administrative aspects of fundholding, to some extent a policeman... I think as an entrepreneur to try and organize good deals.”
E	<b>Opportunist</b>	“A motivator , an innovator and perpetrator”.
F		Lead Partner Not Interviewed.
H	<b>Opportunist</b>	“Several functions, first of all my legal responsibilities to manage the funds correctly, to ensure everything is running smoothly through the office... We have a very very skeleton view for that, very lean and mean and that’s good. Then there is my other function which is to liaise with our fund manager who we share with other practices in town... I collate and put reports to the partners.”
I	<b>Guardian</b>	“Two main areas, one area is the financial responsibility in checking budgets and ensuring that the plan for the budget is OK, that we can live with the budget and checking that it runs smooth at the end of the year. Then there is the area of trying to service development...think about service development...and plan how we might do that and feed it back to partners.”
J	<b>Opportunist</b>	“Somebody to ensure that fundholding moves properly within the practice...we are a democratic practice, there’s no autocracy in our practice at all, you try to set yourself up as a leader...any moves forward that we make within this practice have to be made by consensus.”
L	<b>Opportunist</b>	Did not really answer the question: “Largely we set out a policy as to what role we could play in it. We decided as a team. All of us together that the aim should be not to profit out of it...aim should be to have influence on the services...better... and we will have more satisfaction as well.”
M	<b>Reluctant innovator</b>	“... to be quite honest...I do allow my fund manager, contract manager to largely get on with things because I have every faith in him...what he will do is report to me”.*
N	<b>Opportunist</b>	“...to try to make a broad policy to handle the day to day running of the fund...about leading quite a lot of our fundholding, checking finance. It is a very big role, but at the end of the day you can tailor it...I can delegate a lot of things, this is what I do...to the contract manager.”
O	<b>Reluctant innovator</b>	“I suppose really to keep the clinical and the money side meshed together”

**Table 6.1 Lead Partners’ Views on their Role in Fundholding**

The challenge for the researcher is how to interpret and make sense of the interviews as historical data to illuminate the enactment of the management role. The legacy of

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\* Further analysis of the in depth response to the direct questions reveals the actual; complexity of this GPs’ role

fundholding is seen as important but the researcher did not conduct participant observation as part of data collection which would be consistent with an ethnographical approach often used when looking at managerial jobs (Hale, 1986). If insights are to be obtained from the interviews a framework is needed to analyse the data - what did they do and how did they do it - but taking into consideration that the role taken is undefined. Stewart (1982) suggested that asking managers about their jobs directly can lead to answers that are perceived as right (by respondents) as opposed to the truth sought by the researcher. This is something to be considered in the responses in Table 6.1. Therefore Stewart (1982) presented a practical model for improving management performance through identifying what the jobs are in terms of tasks initiated, emphasised or neglected – essentially ‘choices for the manager’. The model, recognized as a leading conceptualization of the individual in a managerial job (Hales, 1986; Carroll and Gillen; 1987; Noordegraaf and Stewart; 2000; Tengblad; 2006; Pilbeam and Jamieson; 2010) recognized flexibility, choice and personal ways arising from individuals being able to choose. Here it will be used to re-analyse the phase one interview data and organise it to help explain what the GPs did and how they did it, rather than for improving management performance.

The technique proposed by Stewart (1992) is introduced here and adapted for the purpose of understanding the management role taken by GPs. It is relevant and reliable because Stewart (1992) devised a model for understanding managerial jobs and behaviour that accommodated the ‘variety’ and ‘flexibility’ which “explores both the flexibility in the job and the variations in the jobholder’s behaviour”, (p.8). It is a frame of reference in this new context, of GPs in management roles and is helpful in explaining and structuring the observations within the interviews to examine the notion from the doctors in management literature of the possibility of a hybrid manager role which has been explored in secondary care but not in primary care. Thus, the doctor becomes the unit of analysis rather than the general practice organisation itself.

### 6.3 Stewart Model: Understanding Managerial Jobs and Behaviour

The original model aims to understand managerial jobs and behaviour:

*It can be helpful in understanding the general nature of managerial jobs and the differences between them, and can be used to analyse a particular job and to consider how an individual does it...The framework has three categories demands, constraints and choices... Stewart (1982a, p.2)*

Category	Definition	Explanation	Kinds
Demands	What anyone in the job <i>has</i> to do comprising such elements as having to do certain kinds of work and satisfying criteria. It is only what <b><i>must</i></b> be done (as opposed to chosen).	What managers ought to do, because they are in the job description or because their boss thinks the tasks important. Demands are only what should be done. They are an inner core.	1. Overall minimum criteria for performance 2. Doing certain kinds of work as determined by: personal involvement; who must be contacted and difficulty of work relationship; contacts' power to enforce their expectations; bureaucratic procedures that cannot be ignored or delegated; meetings that must be attended.
Constraints	Internal and external factors to the organization that limit what the jobholder can do.	Represent an outer boundary. Limit a manager's choices.	Resource limitations; legal and other trade; technological; physical location; organisational; attitudes of other people to changes in systems, procedures, conditions, good or services produced and work outside the unit.
Choices	Activities that the jobholder can do, but does not have to. Opportunities for a jobholder to do something different from a colleague.	Opportunities for one jobholder to do work different from another and to do it in different ways. Choices are the in-between area between the inner core of demands and the outer boundary of constraints.	1. In <b><i>How</i></b> the work is done 2. In <b><i>What</i></b> work is done

Adapted from Stewart (1982a)

**Table 6.2 A Model for Understanding Managerial Jobs and Behaviour**

Table 6.2 summarises the three main elements of the model. For GPs there were no job descriptions or guidelines, it was a nomination to be pursued and acted on in any way they saw fit. There were no defined boundaries to the role of lead partner, but such ‘managers’ enactment would be subject to internal and external constraints that may arise, in this context partly as a consequence of working in partnership, partly the relationship of a management role to a primary professional role. Thus faced with such choices the GPs are likely to have tackled the ‘job’ in a variety of ways which may or may not be influenced by how they came into the role, the reasons for the practice going fundholding and that role description:

*“There is not a great deal of training out there from a GP side of being a Lead Partner. I think you rely on picking bits out from inappropriate courses...learning on your feet.” (LP<sup>D</sup>)*

Stewart (1992) states that “one way of describing a job is the sum of all the behaviours that are possible in it”. Through a second analysis of the data the aim is to investigate and make sense of that ‘sum’. The ‘sum’ may be defined as the hybrid manager but the formula of that hybrid manager role has not been explored in this context of secondary care. The limitation is that with the sample size here, not all the components of the sum may be found but different components are expected to be discovered.

### **6.3.1 Demands and Constraints**

Figure 6.1 shows how the demands constraints and choices are bounded: demands are core and the constraints bound the choices available to managers. There are many things that a manager ought to do but only certain things that *must* be done both the *work to be done* and having to *satisfy criteria*, criteria such as the functionality of the professional arrangement for doctors (the inner core). In terms of work that has to be done, for the GP, this is interpreted as consultation time, home visits, paper work completion and partnership meetings – all of these things belonging to independent contractor status and role of patient advocate. Constraints on the other hand would be factors that limit what the jobholder can do and may be about resource limitation. The GP may have *time* constraints on the ability to get involved in other work (say as a specialist), *technological* constraints such as the restriction on purchase of in-house

equipment where cost is prohibitive and the constraint *of other people's attitudes* such as individual external work being seen as distracting from the unit's domain.

The size of the bands (Figure 6.1) will depend on how large the demands are and the impact of constraints. The band and scope for choice depends on individual core as a professional and the constraints on that individual. The GP cannot escape from the core demand of being a GP but the notion of professionalism in a welfare organisation, subject to constraints, means he can make choices, for example to become a lead partner and/or to volunteer for committees. Those activities the GP chooses to do and hence to distinguish him/herself from colleagues such as becoming involved in management mean that for this study, the degree of involvement in management as a lead partner may vary.

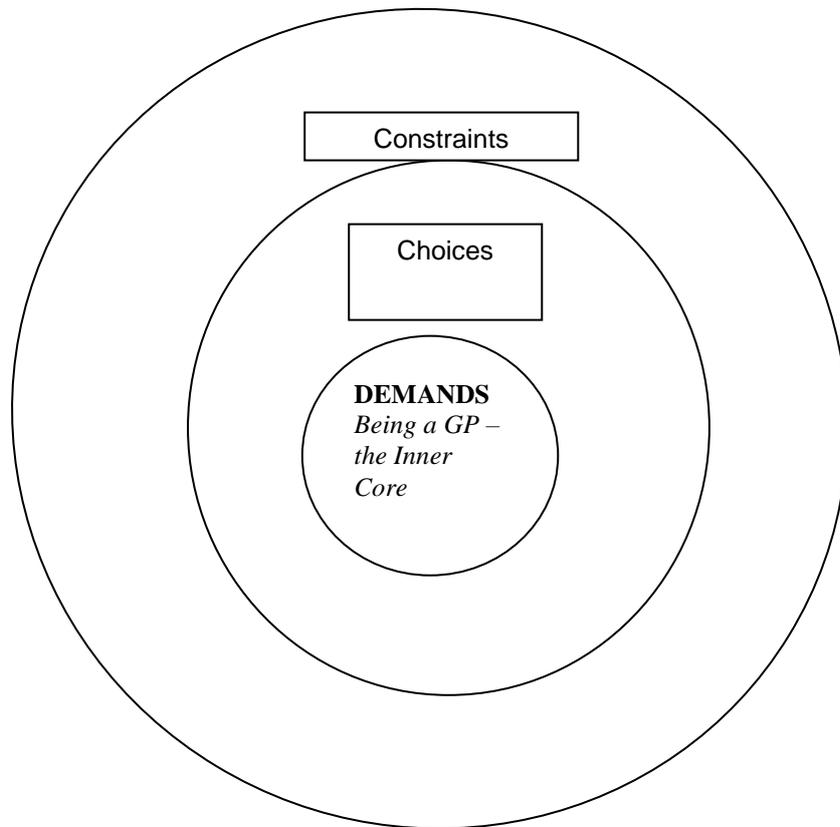
### **6.3.2 Choices**

Choices are central to the framework and make it useful to interpret the managerial work engaged in by lead partners; what work is done and how the work is done. The width of the central band in Figure 6.1 will be determined by the interplay of the inner core, constraints and choices made. The framework is used to incorporate the hybrid manager, what they do and how they do it. The adaption in its simple form can also incorporate the concept of polarisation:

*There are two basic options. One can either do the job as an engineer or as an administrator. [Production Engineer] Stewart (1982a, p.13)*

The parallel in the adaption is that the doctor may choose to do the job as a doctor or as a manager – at one pole the doctor at another the manager. It is choice that allows people to do their work differently from one another and those choices are bounded by the demands and constraints. It is expected that there will be variety with which GPs enact a management role. The Stewart model enables some consideration of choices available to the GPs by applying 1-6 below, to interpret and analyse observations of what they do and how they do it:

1. Choice exists in managerial jobs: choice in what is done and how .There is choice of emphasis of tasks and degree and orientation of liaison, inside or outside, fostering co-operative relationships with people and organisations that are useful.



**Figure 6.1 Demands, Constraints and Choices**  
**Source: Stewart (1982)**

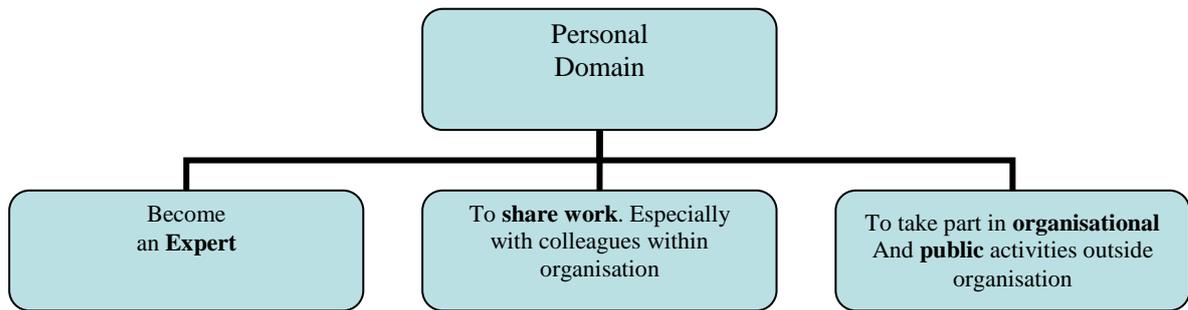
2. Managers can choose boundary management, predicting disturbances and taking preventative action: planning - hence preventative maintenance such as network building; some become politicians, influencing those they need to.
3. Choice of domain for one's unit: involving strategic thinking; choice of domain may also be relevant to career development such as moving on to more senior posts. Choice of domain can be limited by demands and constraints. There is the organisational domain (the unit) and the personal domain.
4. Choice of domain outside one's unit: what is it important for the person to do – personal domain (see Figure 6.2).
5. Choice about work sharing; upwards; downwards; sideways.

6. Choice about becoming an expert beyond the expert as a function of the job – in this case a GP. In the context of choices, expertise is about going beyond the functional arrangements of being a GP and linked to the personal domain. The development of expertise may arise from co-operation with others or it may be individualistic.

### **6.3.3 Unit Domain**

The unit domain is a useful concept in this study and is determined to be the practice domain because whilst the unit of analysis may be the GP the forthcoming analysis does not, and it should not, ignore the context of the practice. Thus the choices in the Stewart (1982) model represent the many variables that GPs in a fundholding lead partner role are faced with at all three models levels: choices within a defined area; choices within boundary management; choices to change the area of work. At the broadest level there is the manager's choice to change the area of work and that might be at the level of either changing the unit's domain (e.g. developing the practice) or developing a personal domain (e.g. personal expertise) or both. The model describes changing the personal domain as having three distinct routes for development as shown diagrammatically in Figure 6.2. The choice of personal domain takes two forms: the involvement in the organisation beyond the GPs own unit; getting involved in activities outside the organisation. A GP may become an internal and/or external expert as a consequence of being the lead partner.

The unit domain is about *what work should be done* within the unit, the activities of the unit in its operations. In the context of GPs the unit domain would be the traditional services they provide to patients as part of the practice partnership under the GP contract. By going fundholding that unit domain has an addition – fundholding but the work to be done has not been prescribed – hence choice squeezed in between demands and constraints.



**Figure 6.2 Choices to change the area of work: Adapted from Stewart (1982)**

Fundholding becomes a choice for the unit domain and indeed fundholding work is *what should be done once* the choice to be fundholding has been made, but studies have not addressed how the GP did that and what they did. The choice for GPs in *going fundholding* was also about the changing the personal domain which emerged as important from chapter 4. Only once fundholding was decided upon could the lead partner role be created starting with a ‘blank canvas’ which, it is argued here, may be informed by not only why the practice went fundholding but why the lead partner adopted that role. Thus, a lead GP is responsible as a member of the partnership to execute the task within the unit domain that they have agreed as per the GP contract and in addition by going fundholding.

By actually agreeing to the lead partner role the GP has already taken “that wider involvement in the organisation beyond the requirements of one’s own unit”, (Stewart, 1982, p.42). Further data analysis will reveal what and how the work is done, shared or not, in order to interpret the level of hybridization, the width of the choices band in Figure 6.1, if any, and the development of personal domain. Therefore, one pervading demand from the primary role of the GP regardless of the GP role is the demands of the core values of GPs: commitment; integrity; confidentiality; caring; competence; responsibility; compassion; spirit of enquiry; advocacy, (BMA, 1995). This is commensurate with the concept of the hybrid manager, the ‘day job’ being the profession of general practitioner and the second element being the management role.

### 6.3.4 Boundary Management

Boundary management occurs when managers think “about how those outside their unit could affect its work and what they could do to avert such disturbances and constraints”(Stewart, 1982, p.25). Stewart found that those active in boundary management often sought to predict disturbances and take preventative action. This is typical of the context of the reasons why GPs went into fundholding rather than being one of the reasons for going into management (Chapter 4) especially for the guardians. It is argued here that boundary management has in fact already been evidenced in the qualitative data. It is represented by the labels in Figure 4.2. If boundary management is about ensuring operations within ones unit are not disrupted (Stewart 1982) then the conceptualization of the GP as guardian is an illustration – they choose to be involved in management to protect the practice and patients from disturbance. However, this does not explain the characteristics of a reluctant innovator or opportunist and indeed it might be too narrow a view to assume that all guardians were really engaged in boundary management. Ironically, the suggestion that GPs are largely reluctant to be in a lead partner role suggest that other GPs (non-lead partners) are boundary managing their personal domain by letting an individual step into the role as categorized (guardian, opportunist or reluctant innovator). Already the guardians can be seen to be protecting the unit domain, preserving the traditions of the NHS and protecting their patients but how does the lead partner manage the new role: expand the traditional unit domain; create a new unit domain; to what degree does that impact on the lead partner’s personal domain; does the lead partner become an expert?

The Stewart model is used for further analysis of GPs as managers; its suitability lies in its flexibility to accommodate the data. This is reflected in the views of fund manager in Practice H:

*...practices are still individuals with a complex partnership agreement and relationships that goes through the whole practice and there is no one model of primary care management and there is no one model for managing fundholding primary care, it's what's best for you. (FM<sub>H</sub>)*

Further the use of the flexible model is consistent with the contention from earlier conclusions within this study that taking one theoretical stance such as the entrepreneur framework is insufficient for the purpose of the study of GPs taking on management roles. In the context of this original study, it is useful to use the Stewart model to cope with this in order to enrich the previous analysis in Chapter 4 and contribute to the literature in Chapter 5 without too many assumptions in the tradition of an interpretive approach.

### **6.3.5 Using the Model: Choices and Flexible Jobs**

This section on the model has describes it and is used to clarify the work done by a group of doctors in management (Carroll and Gillen, 1987). It is applied where the role of the lead partner is not defined and is proved useful because it can cope with choice and flexibility in the role carved out by the doctor.

Hale (1986) following on from Stewart's work looked at what managers do rather than debated who they are, the time spent on work elements, who they interact with, what else they did and the themes and qualities. Hale (1986) used self-recorded diaries, critical incident reporting, essays and participant observation in a number of studies. Noordegraaf and Stewart (2000) reflected on individuals in managerial roles on a day to day basis seeking to develop categories, concepts and theories on the basis of empirical evidence but not such that "the approach is atheoretical: it is about social nature". Both sets of work are based on day to day activity which in the case of this study cannot be captured retrospectively but a secondary analysis with the model as a framework will provide insights to fill the gap in the literature (see Table 5.4). It is not a study of managerial behaviour per se but of doctors who *may* be engaging in management.

The value in this second analysis links to Hale (1986) who recognised that there is no such thing as the managerial job, and supported avoidance of pre-formed categories and variety of research instruments. Hale (1986) also described the interview method as covert, allowing more informal activities to be revealed. Thus interviews are consistent with the choices available to GPs and a way of perceiving and interpreting jobs in personal ways (Stewart, 1982; Tengblaad, 2006) and with different methods

(Hales, 1986). Pilbeam and Jamieson (2010) have used the Stewart model more recently in the educational setting examining the role of the Pro Vice Chancellor in universities as a manager.

#### 6.4 GPs in Management: Being Lead Partner

The preceding sections have introduced the framework (Stewart, 1992) which will be used to analyse the data from the first phase of interviews to identify demands, constraints and choices pertaining to the adopted lead partner role. It provides structure which will enable identification, organisation and subsequent analysis of each lead partner case in order to make observations and inferences from the cases.

The model (Table 6.3) is presented with themed headings for the analysis of each interview (see Appendix 4) and each lead partner has a vignette, a case study, in this chapter based on their own and the fund manager interview. Table 6.4 show the questions used to ask the data about demands, constraints and choices. This enabled a structured approach to the further analysis and interpretation of the interview data.

Demands		Constraints		Choices	
Having to do certain kinds of work	Having to satisfy certain criteria	Internal to the Practice	External to the Practice	How the work is done	What work is done

**Table 6.3 Categorisation for secondary analysis of the interviews**

What aspects of the job are emphasized during the interviews?
What tasks are selected?
Which tasks are ignored or delegated?
Is there evidence of boundary management i.e. evidence of disturbances and constraints from outside the unit being minimised?
Does the lead partner develop personally and/or seek further expertise?
Is work shared with colleagues? If so, who? Peer professional or administrative or 'other'?
What other activities are engaged in as a result of adopting the lead partner role? Are these largely outside the practice and in the public domain?

**Table 6.4 Choices: key questions asked of the data**

The interview data will be used to assess the emphasis of work by considering the evidence from GP and fund manager interviews. Rather than quantify levels of contribution to tasks numerically, each (lead partner and fund manager) can corroborate the relative levels of emphasis on the work done. Secondly, the interview data will be used to analyse what work is selected in order to consider the hybridization/ polarization mix as it is expected that lead partners will make different choices. This will identify how GPs in management engage along the dimension of hybridization and polarisation as choices mean “that some aspects of the job can be given considerable time and attention and others be ignored or delegated”, (Stewart, 1982a, p. 16).

The framework may reveal other choices and constraints as it recognizes the selection of work by individuals which includes maintenance or innovation. Crudely, GPs may maintain their first profession but choose management in order to innovate. The labels (Figure 4.2) enable a way of thinking and linking how the individuals selected their role and how that might link to how they take the management role forward. The literature also identifies the risk of engaging in management and for example, creating partnership tensions (Newton *et al.*, 1993) or personal challenges when balancing between powerlessness and lack of respect (Ong, 1988; Russell *et al.*, 2010).

#### **6.4.1 Proximity to fundholding task: Lead Partner Views**

The direct question of ‘what is your role’ is summarised in Table 6.3 and it is worth noting that when asked directly there is evidence of GPs developing personal domain of expertise and engagement in management. For example LP<sub>H</sub> prepared reports for the other partners based on what he received from his fund manager and LP<sub>D</sub> described himself as the policeman and entrepreneur organizing good deals. On the other hand, LP<sub>M</sub> lets his team get on with it, suggesting little purposive role and at another extreme LP<sub>L</sub> refers to a team approach. The framework enables the direct responses to be classified according to the sub-categories from figure 6.2 summarised as ‘expert’ and ‘work share’ and ‘organisational activities’ in Table 6.5.

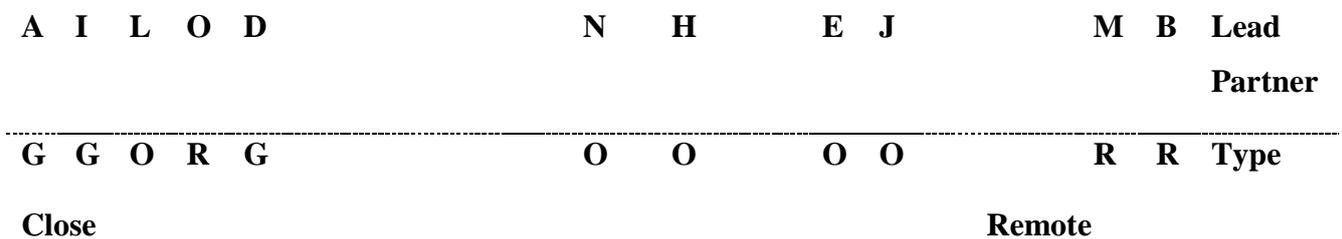
<b>Lead Partner</b>	<b>Class</b>	<b>Direct question: What is your role?</b>	<b>Early indications: Development of Personal Domain</b>
A	<b>Guardian</b>	“...what our activity was, ensuring contracts that look after patients and not take too many risks...extension of role of lead partner in city GP fundholding organisation”	Expert Public Activities
D	<b>Guardian</b>	“As an advisor to the partnership on the financial and administrative aspects of fundholding, to some extent a policeman... I think as an entrepreneur to try and organize good deals.”	Expert
I	<b>Guardian</b>	“Two main areas, one area is the financial responsibility in checking budgets and ensuring that the plan for the budget is OK, that we can live with the budget and checking that it runs smooth at the end of the year. Then there is the area of trying to service development...think about service development...and plan how we might do that and feed it back to partners.”	Expert
E	<b>Opportunist</b>	“A motivator , an innovator and perpetrator”	Expert
F		Lead Partner Not Interviewed	Not Applicable
H	<b>Opportunist</b>	“Several functions, first of all my legal responsibilities to manage the funds correctly, to ensure everything is running smoothly through the office... We have a very very skeleton view for that, very lean and mean and that’s good. Then there is my other function which is to liaise with our fund manager who we share with other practices in town... I collate and put reports to the partners.”	Expert Work Share
J	<b>Opportunist</b>	“Somebody to ensure that fundholding moves properly within the practice...we are a democratic practice, there’s no autocracy in our practice at all, you try to set yourself up as a leader...any moves forward that we make within this practice have to be made by consensus.”	Work Share
L	<b>Opportunist</b>	Did not really answer the question: “Largely we set out a policy as to what role we could play in it. We decided as a team. All of us together that the aim should be not to profit out of it...aim should be to have influence on the services...better... and we will have more satisfaction as well.”	Work Share
N	<b>Opportunist</b>	“...to try to make a broad policy to handle the day to day running of the fund...about leading quite a lot of our fundholding, checking finance. It is a very big role, but at the end of the day you can tailor it...I can delegate a lot of things, this is what I do...to the contract manager.”	Expert Work Share
B	<b>Reluctant Innovator</b>	Refers to fund manager ... “keen to be fairly aggressive, the accountancy background, get the money right, get the contracts right...”	Work Share
M	<b>Reluctant innovator</b>	“... to be quite honest...I do allow my fund manager, contract manager to largely get on with things because I have every faith in him...what he will do is report to me”.*	Work Share
O	<b>Reluctant innovator</b>	“I suppose really to keep the clinical and the money side meshed together”	Expert

**Table 6.5 Personal View on Role and Personal Domain: A cursory allocation**

\* Further analysis of the in depth response to the direct questions reveals the actual; complexity of this GPs’ role

Some of the GPs appeared closer to fundholding through the activities they described by referring to tasks such as contracting (LP<sub>A</sub>) and service development (LP<sub>I</sub> and LP<sub>L</sub>) which can be deemed as developing an expert role in fundholding activities. Some GPs referred to liaising with the fund and contracts managers (LP<sub>H</sub> and LP<sub>N</sub>) suggesting they slightly more removed from the tasks associated with fund managing and willing to share work, especially with colleagues within the practice. At one extreme some GPs implied or categorically stated that they just left it all to fund and/or contract managers (LP<sub>B</sub> and LP<sub>M</sub>) which arguably is neither work share nor expertise development. Such partners were insulating themselves against the role becoming any part of their personal domain, suggesting a lead partner role as titular only and could not even be described as polarisation.

The remaining GPs responded in a much more self-centered way, bordering on narcissistic in two cases (LP<sub>D</sub> and LP<sub>E</sub>). However LP<sub>D</sub> did refer to making good deals and therefore appear close to fundholding and developing expertise. LP<sub>E</sub> said nothing more than the succinct comment in Table 6.3. However the vocabulary of LP<sub>E</sub> does suggest some closeness to the tasks associated with managing the fund and similarly so for LP<sub>J</sub> and LP<sub>O</sub>. In that context the dimension of proximity can be mapped (Figure 6.3). Figure 6.3 attempts to present GPs view on the lead partner role and articulate their proximity to fundholding activities based on what they said their role was.



Key: G= Guardian, O= Opportunist, R= Reluctant Innovator

**Figure 6.3 GPs' view on the lead partner role to fundholding activity:  
Preliminary articulation of proximity of lead partner role  
to fundholding activities.**

There is variety in the lead partners' subjective account of how they viewed the role. The closeness of the guardian hinges upon key words such as 'ensuring', 'organising', and 'financial responsibility'. This contrasts to the remoteness of the reluctant innovator letting other get on with 'things' and deferring to the fund manager. Three generalisation can be made: *some* reluctant innovators did not report an active role in fundholding; *some* opportunist reported shared work and did so more than some of the opportunist who considered they were leading but were not very close to the fundholding activity (e.g. LP<sub>J</sub>); all guardians reported some feature that put them close to fundholding management activities such as contracting and in-house service development. These guardians were reporting some form of development as an expert. Similarly so, one of the reluctant innovators and one of the opportunists also reported a role that exhibited some form of expertise. Thus, guardians kept close to fundholding activities whilst most of the reluctant innovators did not. Opportunists were half way between reluctant innovators and guardians perhaps because they were also concerned with self – the personal domain but they also reported some element of work share in their own description of their role. Thus there is some indication of a continued role in the management once fundholding went live. Thus from a direct question these are the inferences from the data:

1. **Guardian lead partners** (enthusiastic GPs who lead a practice going fundholding for negative reasons) perceive their role in fundholding as an expert which includes various activities: contracting for patient benefit; developing services; not taking too many risk; advisor to the partnership; taking on board financial responsibility.
2. **Opportunist lead partners** (enthusiastic GPs who lead a practice going fundholding for positive reasons) perceive their role in fundholding as: a motivator; an innovator; an overseer; a liaison point between the fund manager and partners; team working and work share; broad policy maker; delegator to the fund management team.
3. **Reluctant innovators** (unenthusiastic GPs who lead a practice going fundholding for negative reasons) perceive their role in fundholding as 'hands off'

they are remote from the lead partner role. The title of lead partner is a misnomer as they describe their role as taking work share to the extreme with a high degree of delegation.

#### **6.4.2 Doctors in Management: Case Studies**

The section considers the lead partners enacting a management role in more depth: what did they do and how did they do it using the interviews covertly (Hale, 1986) and making sense of them with the framework. The individual lead partner cases are based on the themes emerging from the analysis (Appendix 4) and present the new themes from the data for the first time.

##### **6.4.2.1. Lead Partner A: Guardian**

LP<sub>A</sub> was a guardian and therefore enthusiastic in order to protect the practice. He was active in strategy, contracting and performance management of contracts on a monthly basis (see Table 4.8). He admitted his continued dominance in his participation in fundholding which suggested few peer internal constraints through the attitudes of other partners, or none that bothered him enough to restrain his lead partner activities:

*...had done a lot of ground work and was very interested in it, and put pressure on the others for that [chosen] partner to be allowed to continue as lead partner. (FM<sub>A</sub>)*

However there was some evidence of the demands of the real job time constraints as a result of taking on the role of lead partner due to ‘doctoring’ activities:

*...I need a day and half with fund manager every week. I get half a day uninterrupted.” (LP<sub>A</sub>)*

The lead partner was driven by enthusiasm for the scheme and was both inward and outward looking of the organisation. This GP did not work share with fellow partners but did so with non-partners, that is the fund manager. There is evidence of developing a personal domain outside the unit domain. He became involved in the public participation in fundholding groups, taking part in activities outside the organisation hence became an expert. In terms of how the work was done, the fund manager adopted a data collection role and the lead partner used the information in negotiations thus there is a hierarchical structure; information passes up and is used at a higher level. This is indicative of work share in the management role embedded in

the practice sharing the management role with the sub-ordinate fund manager but not with fellow GPs.

The lead partner recognized that he was a manager as lead partner but not that he has been ‘trained’ to that role:

*To be honest that [to go on a management course] would do me an enormous amount of good...to go and learn where all the holes are. Yes, to learn what my weaknesses are, what my strengths are, how to rein in my strengths and not to dominate. (LP<sub>A</sub>)*

The Lead Partner enjoyed that role, despite the extra work it has created:

*What happened since we went fundholding is now I work harder and harder and harder and I am tired and I get resentful of the fact that I work so hard I spend a lot of my time thinking about fundholding...I just get on with it...I went on a few courses on negotiation skills... but there were things I set up myself... we get nothing for sitting on health authority committees and stuff like that, you do it because you are interested. (LP<sub>A</sub>)*

He enjoys reading and thinking about what the practice should be doing and the role seemed to have given some creative licence enabling him to become an expert in that area. He admits to ‘spending a lot of time thinking about fundholding’ but constrained by the lack of detailed activity in management information which he could use to predict trends and costs over time. Thus, at this point in management he is constrained by technology and frustrated by the computer package when compared to what he can do with Microsoft packages. Further, he was frustrated by the financial constraints of the fundholding management allowance, which restricted the type of fund manager he would have ideally appointed in order to share the work. This lead partner operates as part of the fundholding team but delegates the task of data and collection and information gathering to the fund manager. He exhibits the role of decision maker and external negotiator. He suggest that he spends most of his time on strategy and individual patient problems indicating BMA core values are still strong in his hybrid manager role and consistent with the role of guardian. In terms of demands, this lead partner chose to allocate specific time to fundholding management as indicated by the earlier remark on the reality of desiring one and a half days and getting only half.

The earlier fundholding budgets allocations had some slack and were an incentive for partners to encourage their practices to go fundholding:

*...the big screwdriver...now we do not have much room to manoeuvre... you need that amount of room just to be able to sit across the table and actually negotiate with somebody.... (LP<sub>A</sub>)*

The incentive of budgets' and lack of prescriptive protocols seemed to spell 'freedom' as articulated by LP<sub>A</sub> on his thoughts of if they had not been accepted after his hard work on preparation for fundholding:

*...[if] this doesn't get through, I will go back to what I used to do before...If somebody said would you like to do general practice again I would say no I don't like it. It's not fair. We are meant to set all these targets in terms of helping people, initiating change in people's lives today to make them healthy and to keep them healthy...and I have not lost any of the wanting to do that sort of thing.(LP<sub>A</sub>)*

LP<sub>A</sub> had moaned in the first instance about the amount of time he spends and yet it is clear that he has been sitting on external committees which develops his personal domain. Stewart (1982) classifies networking as a common method of boundary management indeed LP<sub>A</sub> commented that through involvement on committees he is able to obtain advice. Thus, this guardian continues to protect the practice partnership unit domain.

#### **6.4.2.2 Lead Partner B: Reluctant Innovator**

LP<sub>B</sub> was a reluctant innovator:

*I had absolutely no desire to be involved in the commissioning of care and the negotiating of contracts and talking to consultants...It just became impossible for us to do any development work and to pursue any of our interests in health without doing it...It wasn't a financial decision. Both of us reluctantly took it on – me particularly...I found myself doing it and now we are so deep in to it ... it's going to be difficult to pass it on, so we[LP] are lumbered with it, to be blunt (LP<sub>B</sub>).*

Although 'lumbered with it', he was not active in day to day activities and interacted with the data on a monthly basis (see Table 4.8).

Management teams were in place, each headed by a partner. The lead partner had worked jointly with another partner before (referred to 'screwed down management systems,' LP<sub>B</sub>) and the Practice Manager on technical development in the practice and the two partners decided to take on the lead partner role together. Thus the

personal domain of the partner was already developed in expertise in some management role and given the small management teams headed by partners there was evidence of work share with partners. The existing practice manager took on fundholding:

*We already had two partners in place doing technical management of the practice with the manager... you can't separate practice management from fundholding...each affect the other. There was no question of needing to get anybody else. (LP<sub>B</sub>).*

Essentially the work was done by the practice manager, a case of “employing people to do the donkey work to administer it” (LP<sub>B</sub>). In terms of work done the lead partner is merely tempering the aggressive business and finance minded practice manager – overseeing rather than being operational, “to temper some of that, and also bring it back down to the level of the patients”. Thus the lead partner used the demands of the primary role of being a GP as a constraint on the fund manager who was effectively leading the show. Some practices in this study had employed fund managers from a non-NHS background to delegate some of the fundholding management to, for example, Practice A, H, J. However, in Practice B they were somewhat pioneering in that their practice manager who also became fund manager was already strongly private sector. He became the link between management of fundholding and keeping the patient at the heart of the ‘business’ delivered through a bureaucratic meeting structure. Though reluctant, over time the partners found fundholding to be a good tool but the Lead Partner was forthright about his role in management:

*I am more concerned with the strategy, rather than the mechanics, the management rather than the administration... I mean I hate the thought of being involved even more with responsibility for accountancy, if you like, and management of the practice. (LP<sub>B</sub>).*

LP<sub>B</sub> had his personal domain clear in his own mind on reflecting on what he spent most of his time on:

*It's really about policy decisions, about general trends, like are we going to move into the private sector? (LP<sub>B</sub>).*

In summary, not only was the unit of the practice partnership well developed but also the personal domain of the GP who took the role of lead partner. Boundary management, intentional or not was key. The focus for this lead partner was the

personal domain of being a GP and not the professional personal domain development which would have been demonstrated by activity external to the practice.

#### **6.4.2.3 Lead Partner D: Guardian**

LP<sub>D</sub> is classified in an ‘ambivalent’ partnership. He was one of the GPs that had little involvement in the running of fundholding according to the analysis in Table 4.8 (shaded area) for frequency of interaction with data. Basically, he had set the practice fundholding and that was that:

*...I think as an entrepreneur to try and organize good deals for the practice...to try to generate some fund savings. Certainly to bring in ideas. (LP<sub>D</sub>)*

Two partners had volunteered for the lead partner role as the scheme began, including himself as the new partner when he joined in the preparatory year of the scheme. He refers neither to internal or external constraints nor any reluctance on his part in taking the role. He does not appear to network beyond the practice and seems to ‘fly solo’ in fundholding. He briefly commented on the constraint of the lack of training available to the role, that reflects the undefined nature of it, and the lack of accurate data. He sees himself, as least in part, as an ‘entrepreneur’ seeking good services at a good price but divorces himself from concerns with the data processing and concerns himself with negotiation and planning. A new member of practice staff was appointed to the computer related type work as computerisation was one of the reasons to join the fundholding scheme and the appointment became fund manager. The day to day administration is away from the lead partner role as evidenced by the compliance role of the lead partner, almost auditing and review of the work that is done:

*...important that you look at what you’re doing and analyse it and be willing to change... trying to observe broad guidelines that we put down on referral patterns and prescribing. (LP<sub>D</sub>)*

In terms of personal development and seeking additional expertise, not only was participation in the computing of the scheme ruled out, he was very clear about what aspects of fundholding were *not* for him, with reference to two other aspect of the scheme and his involvement:

*Some lead partners really just sign invoices I think and not much more than that. Other lead partners do do the accounting side. I can't see much point in being a partner in a practice and doing the accounts really. And I think the role I have here is about right but yes, I have not found a course that has been a reflection of the type of job I do.” (LP<sub>D</sub>)*

The partner implies that he does not get involved with the scheme within the practice. Thus he does not work share with either the partners or the fund manager and does not purport to seek expertise in fundholding but does like the outward facing deal making activities. Thus public activities may be limited to co-operation and deal making, which is contracting.

#### **6.4.2.4 Lead Partner E: Opportunist**

Practice E has a lead partner who is an opportunist. From the start of first wave fundholding he led with enormous enthusiasm and flair. He was active in contracting and performance management on an annual basis (see Table 4.8). In his own words ‘motivator, an innovator and perpetrator’ seeking relief from the boredom of general practice. This lead partner refers to the demands of the role:

*...all the extra paper work and for the first few years instead of getting less, it got more and we got bogged down in preparing business plans which were never read.. I think somebody actually put ‘we are going to introduce Popeye and Olive Oil in as counsellors’... a complete waste of time and they were there to conform to some mythical civil servants idea how this should be run. (LP<sub>E</sub>)*

He did not work share with fellow partners and was the fundholding expert. Further, there were possibilities for internal constraints to the way that the work might have been done as the other partners wanted to leave the scheme:

*...because they don't like x spending time at meetings and away from the practice. They want him to see patients and not go away from the surgery.” (FM<sub>E</sub>)*

The lead partner leaves the management of the fund to the fund manager, there is no evidence of being hands on which is summarized by the fund manager:

*Oh actually that's not true – there's one thing he asks for on a regular basis and that's ‘how many savings have we got left? ...I'm affectionately known as the boss... (FM<sub>E</sub>)*

And also by the lead partner himself:

*I don't need regular check-ups because I have a reliable team and I have to rely on them so if you like the 4Ds apply –decide something's got to be done; do it yourself; delegate it and if you can't do any – dump it. (LP<sub>E</sub>)*

For this lead partner the role is a means to an end. Therefore the evidence from the interviews suggest that he is interested in outputs rather than the processes of fundholding and at first it seem there is no interest in the means of achieving the outputs. However, that would be the wrong conclusion as he did negotiate and contract with providers. There was also membership of the city fundholders group, being on the executive committee with some aim of influencing policy within the region and like LP<sub>A</sub> the personal domain by getting involved in activities outside the organisation. Therefore there is an element of boundary management.

#### **6.4.2.5 Lead Partner F: Reluctant Innovator**

In Practice F the lead partner was not keen to be interviewed; in fact on approaching this practice the fund manager suggested that his GPs were reluctant fundholders. He was not active in day to day activities and interacted with data provided by the fund manager on an annual basis only (see Table 4.8). The partners were not interested in fundholding and did not have the enthusiasm. Nevertheless, using the fund manager interview as proxy there is evidence of how the work is done and what work is done by the lead partner.

The role was shared out, between partners as explored in Chapter 4. No one Lead Partner took a dominant role and could if they had wished to. At first, meetings were convened by the Fund Manager at regular intervals, but these petered out to quarterly events. The Fund Manager was left to a dominant role with over 30 years NHS experience and seemed very much left to his own devices. When asked what the Lead Partner did with the information the evidence suggests that one of the Lead Partners took a role in negotiation with parties external to the practice and that was far as he took the role:

*Hopefully he absorbs the blessed stuff and remembers it! But basically he will save that for when is in a meeting with providers and when there is any negotiation with providers, and for discussing matters with other members of the partnership who are obviously not lead partners. (FM<sub>F</sub>)*

And on fundholding itself:

*I take a broad view of the whole lot... I had the umbrella view, it wasn't a problem it was just like another segment added on. (FM<sub>F</sub>)*

#### **6.4.2.6 Lead Partner H: Opportunist**

The Lead Partner joined the practice just before the practice decided to go fundholding, acting as understudy to the senior partner in preparation for the role. He did not take an active role in day to day activities and interacted with data provided by the fund manager on a monthly basis (see Table 4.8). He may have taken the job with a view that he would be getting involved in management and operate beyond the medical in a practice that had a 'modern structure of practice management' (FM<sub>H</sub>). He had strong views about the larger picture of management in the NHS, an apparent factor in his adoption of the lead partner role. He was quite clear on what his role was (see table 6.2). These circumstances infer that work share was not really part of his lead partner role. Prior to the incumbent lead partner taking on the role the then practice manager took a dominant role in fundholding but was relieved of that duty as things became more complex. The lead partner reflected on his naivety in what he thought his involvement would be like:

*...now seems like it would just be a tea party. It would be beautiful to go back in some ways, some simple ways, some innocent ways... (LP<sub>H</sub>)*

In terms of how the work was done, this lead partner is hands on and this is demonstrated by what was done and leadership from the 'front' and across the practice boundary, including networking with other fundholders:

*...put it all together for reports to the partners meeting where I have to sadly, more often than not, just pull them up on their advent ways, tell them how badly we're doing...checking everything is going along smoothly...Reading various documents that come my way, binning quite a few of them and preparing my own reports. I'm a great believer in one sheet management. (LP<sub>H</sub>)*

It seems that there were some internal constraints placed on this partner which he resolved in his managerial role, however at the later interview with the fund manager that person recognised that 'there was still some strain within the practice':

*There was a bit of a problem a little while ago perhaps, where it was me versus the partner, but that has been resolved now after a couple of vibrant partners meetings where I put to them the problem which the partnership has and we, as a partnership, are going to solve it.” (LP<sub>H</sub>)*

For practice H an external constraint of having one key major provider who the practice contracted with, impacted on the execution of the managerial role which impacted on the management of fundholding by the particular health authority. Similar practices in the locality were also contracting with one main provider and the lead partner ‘saw advantages of several practices being linked together and being able to share experiences...increasing power when dealing with providers...rather than risk being bowled over by them’. This influenced how the work was done by the lead partner in that he appointed a fund manager who was shared amongst six practices. The lack of dedicated fund manager may also mean that more work came to the lead partner and thus more work share in the problem solving across the other GPs in the practice.

How the lead partner conducted his role in management is indicated by what work was delegated to the fund manager and the nature of the appointment, taking a recruit from a purchasing background to align with the need of ‘monitoring performance of contracts’. For this lead partner the work to be done involved control by monitoring activity on contracts based on contract matrices produced by the fund manager:

*The problem we have with the computers, they are accountancy tools, and they’re not management tools, so they give final month closure but they assume activity is the same 12 months of the year. (LP<sub>H</sub>)*

Further, whilst this lead partner was fully conversant with fundholding and arguably uses it to assert power and authority within the practice and externally with providers, he distinguishes between contracting and record keeping as an administrator ‘does all the compilations and reports and deals with the auditors’. There is a clear internal role of the administrator within the boundary of the practices and an obvious out of the practice role for the fund manager concentrating on the contracting. All of this was under the watchful eye of the lead partner.

The lead partner also refers to core values and the demands since as far as he is concerned, a ‘GP sitting in his consulting chair with a patient, the fact that we are

fundholders should not affect his clinical decision'. Therefore similar to practice A, there appears to be a hybrid domain developing as well as a hybrid manager:

*I will talk to you now but I know that in an hours time I'm seeing patients again...I'll see Alice with a severe osteoarthritis. I have that. I'm always drawn back to the thing at the end of the day. (LP<sub>H</sub>)*

Core values also emerge in the way the lead partner chooses to manage with a practice ethical principle that the person in charge of fundholding cannot be involved in other practice finance, 'demarcation very clearly because that is good management practice'. The fundholding domain developed as the lead partner's personal domain.

The lead partner engaged in other activities including being secretary of the city's fundholders group. The lead partner and fund manager both concluded on management in the practice and how it was enacted:

*...become more streamline, more efficient and we're getting better at. I mean I'm getting better at saying not to useless meetings, being much more direct...what's that thing about you get data, then you get knowledge then you get wisdom... the Health Authority does not have the knowledge...they're not clinicians, they do not know what is going on in the front line, therefore they need our experience. I think there has always been a need for a partner to be involved in some form of commissioning activity. (LP<sub>H</sub>)*

*...they were the first fundholders that I worked with that started to prioritize or ration elective care, tinker with it to stay in budget and that's a managerial, a practice principle from GPs (FM<sub>H</sub>)*

#### **6.4.2.7 Lead Partner I: Guardian**

The lead partner in Practice I was a guardian. He was active in contracting and performance management interacting with the data on a monthly and quarterly basis (see Table 4.8). With an interest in the business side of general practice, he adopted the role in the absence of others wishing to be involved since it was viewed as a 'business venture'. Once operational, under the original non-NHS background general practice manager, fundholding was executed as much as it could be as separate from the general practice domain.

*...it was felt we could just run fundholding in the background with very little change in the clinical experience [initially]...prior general manager from non-medical background...great difficulty adapting to NHS culture... (LP<sub>1</sub>)*

*with as little disruption to the normal running of the practice as possible, primarily because the GPs that were anti-fundholding didn't want to see it making a difference (FM<sub>1</sub>)*

However:

*...cannot be done despite initial enthusiasm to do so...It very quickly became thought of as a central theme of the practice, we were a fundholding practice and this is what the practice was about (LP<sub>1</sub>)*

It seems early resistance to fundholding becoming an important element of the practice domain was futile. Indeed, certain work was deemed to be necessary by the lead partner; financial responsibility and service development. The role of financial responsibility was as an independent individual, acting as lead partner, within fundholding. There was shared communication between the fundholding domain and the general domain in the enactment of service development by taking matters to partners and taking matters they raised into account, an element of formal planning. Thus non-lead partner work share was in the form of consultation, more overtly than LP<sub>H</sub>.

The lead partner had chosen what work to do. He settled into that work alongside the fund manager who had been appointed by the non-NHS general manager (who later left as the role did not work out, attributed partly to the non-NHS background).

*I think accountants are the worst people to actually run a fund to be honest... tried to run everything like a business ... NHS is about people, it's not about business or finance... led to him leaving in end..., (FM<sub>1</sub>).*

Therein the Fund manager grew into his role and adopted “fuller aspects of fund managing i.e. negotiations and control”.

*[I am] the odd job man. Basically I do everything to do with any kind of finance...IT, maintenance, commissioning, all the lot (FM<sub>1</sub>)*

With regular half day meetings between lead partner and fund manager the work done included signing off invoices and looking through month end accounts “basically I don't get involved in any of the day to day figures... I'm trusting, relying on him and the system.” When necessary the lead partner would request working list information

to manage the waiting list and financial updates when required to support service development in the context of clinical development which he explained as fund management meaning service development i.e. how are going to provide a service. Despite describing this trust and lack of involvement the Fund Manager in Practice I described how he give the Lead Partner ‘everything’ form spreadsheets and written reports but that “if there’s a person who has gone to a weird and wonderful hospital for a weird and wonderful operation he might question the partner’s judgment more on a peer review than judgment of the case”. This indicates that the lead partner would not interfere with clinical decisions. Further the fund manager reveals that the Lead partner writes reports to other partners while the Fund Manager writes the annual business plan, seemingly Lead Partner acting as the cross over between the boundary management by other GPs.

Thus the fundholding unit grew organically but with hindsight the Lead Partner would not have let that occur:

*Critical aspects were deemed to be good contracting, good negotiating and a cornerstone really, keeping your priorities clinical, having a view to quality as well as cost. I would have identified those people [being key staff] much more clearly and identified their tasks much more clearly instead of letting it grow in this sort of organic way that it did (LP<sub>1</sub>)*

There were little internal constraint in this practice or indeed any indication of external constraints; however growth by organic means left the practice isolated when they stepped away from being part of informal consortia. This led to them being “isolated” from developments that would have been beneficial to the practice. In this case the lead partner purposefully seemed to have not engaged in the public activities, even with fellow consortia members themselves.

#### **6.4.2.8 Lead Partner J: Opportunist**

The Lead Partner took an active external role in fundholding before it was adopted in the county in which the study took place. He undertook the role because of his support for fundholding and his knowledge of the scheme also advising the Health Authority. He was not active in day to day activities and interacted with data provided by the

fund manager on a monthly basis (see Table 4.8). He was constrained internally through the democratic partnership style (no senior partner structure in this practice, all equal) as his leadership role aspirations were held back “as I say we are a democratic practice, there’s no autocracy in our practice at all, you try to set yourself up as leader... {long pause}”. There was little reference to demands as the fundholding path seemed to have been smoothed by the recruitment of a high ‘calibre’ fund manager that was shared with other practices. Each locality within the Health Authority had a shared fund manager and each practice within the locality retained its own fundholding budget. It seems fundholding could be isolated from the practice domain through recruitment and fundholding organisation so that any development of the fundholding domain was restricted, if the lead partner chose that.

*I think fundholding helped them to come to terms that they needed a proper manager...and to let go of those traditional roles that each GP had...they’ve a more structured management team and really the management skills they lacked as GPs, their responsibility has been passed on to the managers to manage rather than them doing it. (FM<sub>J</sub>)*

In terms of how the work was done there was little hardship in being fundholding:

*Data collection...it just slid in very gently and what we did was we shielded the partners as much as possible...minimal amount of change imposed on the practice by fundholding. (LP<sub>J</sub>)*

*...totally separate in the early days (FM<sub>J</sub>)*

However the work that was done is simplistic to the lead partner because of the choices in what work is done. This is embodied in the response when asked about critical aspects of fund management to which there was a shriek of laughter and “what do you mean by fund management? It depends on your philosophy doesn’t it really?” Digging deeper the interviewer gave examples e.g. contract negotiation but the lead partner suggest “ask the fund manager because he’s the one who’s done all that for us .... We get information every month”. Indeed LP<sub>J</sub> receives reports “as often as I can and the fund manager will tell me whether we’re over or under in any particular area”.

*I used to spend time looking at individual contracts, I now basically just read the excellent summaries...exactly the position where we are... delegation is the name of the game...I just give a touch every now and then just to make sure things are going right...clinical stuff comes first then the other stuff comes later. (LP<sub>J</sub>)*

This implies that he does not even interpret the data and has it done for him although, “if there’s a problem area then I’ll look even deeper detail than that”. In the past a previous fundholding computer package had enabled him to produce trends but that package had since been replaced. The lead partner was focused on data and its collection for transparency as “fundholding as an ideal opportunity for general practitioners to measure precisely the needs of their patients for secondary care”. This focus on data and lack of use of the information suggest that the lead partner was not active in management or acting out a leadership role, nor did he develop his professional/personal domain with involvement in external activities. Indeed, he became more introverted as the opportunity to become an ‘expert’ in and develops a personal domain in IT; this GP’s next mountain (Glennister *et al.*, 1992; Fitzgerald; 1994). When he could not link that expertise in that personal domain to fundholding his interest in fundholding waned. LP<sub>J</sub> was apparently trying to make fundholding fit into his extant personal domain and failed.

#### **6.4.2.9 Lead Partner L: Opportunist**

LP<sub>L</sub> was an opportunist with a keen desire to develop in-house services. At first it seemed that the lead partner was involved in list management on a day to day activity basis as well as with the interaction with data produced by the fund manager on a monthly basis (see Table 4.8). Demands and constraints were unlikely to evolve as he had seemingly limitless choices in how and what work was to be done in this role:

*...ball was left with me to start playing with it as I wanted. (LP<sub>L</sub>)*

However, the interview was short relative to other lead partners and very focused on achievements with infrastructure and services with little comment or opportunity to discuss what work was done and how the work was done. This lead partner was very difficult to interview and did not have a great deal to say but on reflection it may be that he really did not have much to say as he delegated to the fund manager in a collective ‘we’:

*We analyse, at the end of each month, when the accounts have been closed we go through the financial statements, we go through our waiting list, we go through the priority list...a batch of reports...I am very pleasantly encouraged with the information that I have been receiving*

*through my contracts manager...spend most of time on management of lists and make sure that we are not overspending.*

Similarly on the critical aspects of fund management, “I think you’re better asking the fund manager but I certainly think you have to define your aims first and work towards those.” There was no indication of the development of any expertise or public activities internal or external to the organization.

#### **6.4.2.10 Lead Partner M: Reluctant Innovator**

LP<sub>M</sub> was a reluctant innovator whose views were mollified as fundholding progressed, having taken a ‘completely different view’ of fundholding, because she had found that ‘being in control of your own budget and your own destiny gives you an awful lot of power’ to deal with problems that arise in relation to the provision of secondary care. On the face of it she had little involvement in fundholding according to the analysis in Table 4.6 (shaded area). However, a sense of commitment to do the job properly emerged with few demands and constraints imposed by apathetic partners (“apprehensive...still are and don’t get as involved in fundholding...”FM<sub>M</sub>), she allowed the fund manager to concentrate on a contracting function leaving the GPs (and especially herself) to get on with clinical. However over time she increased the scope of the work of the fund manager. LP<sub>M</sub> became more trusting and was able to hand over aspects of the task of fundholding to the fund manager:

*...there’s no point me wasting time entering referrals and messing about with reports and things...to be quite honest and say that I do allow my fund manager. Contract manager to largely get on with things... he looks at budgets and things. What he will do is report to me, so I monitor what’s going on... some GPs are much more into contracting side which I’m not*

Thus the more mundane administrative tasks were left to the fund manager but there was some strong self- denial of management activity by the lead partner. It was clear that the lead partner in practice M had an increasing professional portfolio and was instrumental in the site expansion in terms of unique services in secondary care, which the fund described as development being ‘dramatic’. Thus the personal domain for LP<sub>M</sub> burgeoned as, for example, she indicated her relationship management role on behalf of the practice with external bodies, including the Community Health Trust and sorting out project areas such as in-house counselling, prescribing, emphasizing

that it was “clinical work not only to save money, but to improve patient care”. She adopted a distinctive gatekeeper role, by using the information from the fund manager for strategic decision making:

*I look at it (laughter), look at all these figure and, no what we do is if we're looking as though we're going to overspend which happened last year, we'll deliberately stop the hospital operating...keep an eye on prescribing budget... so I've done the referral analysis by partner and speciality” – looks at service implications*

Yet asked directly about the aspects of management:

*Critical? I think you've got to have the right manager in my view. I am not a manager, I'm a doctor, I wasn't trained as a manager... have a fund manager that you can trust...liaising with Health Authority... keeping you informed*

Though in denial she does meet with the fund manager, reviews monitoring reports and attends performance review meetings, being “reported to and we do the waiting list management”. This was supported by the fund manager who described the two types of reports he produced as the ‘print-outs and the monitoring forms’ which he then hands over and they discuss in a Wednesday morning briefing, thus a clear bounded meeting time. Although she has enjoyed developing practice services, she does not really see herself as a manager but rather a doctor who has picked up certain skills, commensurate with the lack of defined role in the lead partner role and the choices faced. For GPs it is evident that the skills acquired as a result of being lead partner will be skills of choice rather than being imposed. If not imposed they were already developed within their professional domain and in some cases fundholding was increasing that domain through either work share, development of expertise or increase public activities beyond the practice boundary.

#### **6.4.2.11 Lead Partner N: Opportunist**

LP<sub>N</sub> went into the role knowing he could ‘tailor it’ particularly in respect of contracting. He was an opportunist and despite being ‘conned’ into taking on the role he facilitated a structure that left him with control over ‘broad financial affairs’. He was active in contracting and performance management interacting with the data on a monthly basis (see Table 4.8) but did not indicate public activity because he only made grand policies and had a contracts manager. This was a difficult interview with

the lead partner being emphatic on every point and being quite clear that there was no more to be said once he had delivered his precise answer. A clear fundholding team was in place, across three practices, with a contracts manager and fund manager dedicated to the fundholding initiative:

*I don't spend too much time, once a year when the contracting process is in progress...I give them advice yes, we will have to take the contract with this provider, but not that provider. I know what my patients want... they like to go to a nearer hospital. I only make the grand policies and then I will leave it for the contract manager and the fund manager to make the final negotiations on my behalf (LP<sub>N</sub>)*

As an opportunist he was a keen fundholder:

*...In the long term it is good for patients, it is good for the GP and it is good for the Department of Health because in the long term it will save them a lot of money. It is incentive for the doctor, not financially for themselves but for the practice, it is better. It is the incentive for the doctor to control the finances in her practice, it is hard work, but at the end of the day it pays dividends and it will be a great shame if fundholding is cancelled altogether. (LP<sub>N</sub>)*

There was some internal constraint in the tensions exhibited by GMS staff thinking “that the fundholding people are treated differently, but they are not... [because] now our attention is divided between GMS and fundholding so they think that we are giving them a bit more attention”. This is indicative of the divorce between the practice unit domain and fundholding domain as they were separate at first. There was further evidence of their distinctiveness by recruiting an external person as nobody was deemed qualified from within the practice. Therefore with a separate management structure for practice and for fundholding there was a “dedicated staff” supported by “specialist training”.

In terms of how the work was done the lead partner received information from the fund manager which he goes through “and pass them in my usual monthly meeting with my partners, and of course he [fund manager] has to write a report at the end of the year”. He discusses the information with the fund manager and with the contracts manager. Further:

*I don't involve myself with the software, people upstairs do... We saved on drugs, we taught ourselves the discipline of prescribing... of referring people to hospital... (LP<sub>N</sub>)*

Indeed, in respect of targets the fund manager described LP<sub>N</sub>'s targets as 'extreme' relative to the other practices he worked for perhaps reflected in this section of the interview:

*At the end of the day fund management is about prudent financing, if you have got a good contract manager, a good fund manager who is going to negotiate good contract for you... make some saving... plough the savings next year for the service of the patients and this is very important. (FM<sub>N</sub>)*

The lead partner talks collectively. He was adamant he would not go for big commissioning beyond a practice base budget.

#### **6.4.2.12 Lead Partner O: Reluctant Innovator**

The lead partner was a reluctant innovator with little involvement in fundholding according to the analysis in Table 4.8 (shaded area). He volunteered for the role but had few strong views about it - or kept them to himself. His answers during the interview were closed and almost dismissive with an undercurrent of inevitability and tang of disinterest in the pertinence of the questions. There were a lot of 'supposes', for example:

*I suppose I volunteered myself [laughs]. (LP<sub>O</sub>)*

*I suppose information from the contract manager is more to do with figures. Nothing much clinical...we think about it and report back. There's no formal written things going backwards and forwards... I suppose it's looking at and signing invoices. It sounds very boring doesn't it really? I think that probably the main [thing I do]. (LP<sub>O</sub>)*

*...the attitude is more laid back...practice itself is quite tranquil...everything developed slower (FM<sub>O</sub>)*

The divorce between the doctor here and the scheme itself was very pronounced but the fund manager confirmed that was the nature of the practice. There was no

indication of LP<sub>O</sub> developing a distinct personal domain either before or during fundholding. However:

*I think they didn't realize what was required...to be honest I don't think any practice fully understands what they need to do to make fundholding work...a lot went in with their eyes closed... to be honest to make it work you don't need to be a GP and you don't need to be a practice manager...what you do need it a wide range of management experience and you need experience of working in the hospitals (FM<sub>O</sub>)*

*I think the fund manager, who is also the practice manager, is really an interface between the medical side and the accounting side. (LP<sub>O</sub>)*

There was a contracts manager and a fund manager plus the original practice manager indicating the separation between practice and fund management but also the separation of the different management activities. Throughout the interview with this doctor it was clear that fundholding was about data and numbers and little reference to management issues of the scheme for him or his partners. This latter comment was an instance where accounting was indeed only a technique for organisational order (Table 2.1).

## **6.5 Doctors Engaged in a Management Role**

The previous section has analysed the interviews by adapting the Stewart (1982a) framework and applying it to interviews to reveal some of the choices about what the lead partner did and how they did it. The analysis summarised (Table 6.6) gives insight relative to the type of lead partner (Chapter 4). This will enable consideration of the factors that contribute to engagement in management by doctors in primary care based on the choices they made.

### **6.5.1 Demands and Constraints**

From Appendix 4 it is evident that demands and constraints did not feature strongly as the columns are not populated when the framework is applied to the interviews. Demands are only what should be done and with no clear description, the main demand is the primary role of being a GP. It is the practice that has chosen fundholding and there has to be a lead partner, although there is evidence that fellow

<b>Lead Partner</b>	<b>Framework</b>	<b>Relationship with Fundholding: What they did and how they did it</b>
A Guardian	Internal Expert External Expert Public Activities	Dominant in fundholding. Monthly activity with contracts and performance management. Strategic. Time constrained. Develops personal domain becoming an internal expert (not work sharing) within the doctors' partnership in fundholding but also an expert beyond practice boundary engaging in public activities (external expert). Work shares the management role with fund manager. Decision maker and external negotiator. Boundary management via networking . <b>LP<sub>A</sub> is an expert (internal and external fundholder) and a strong hybrid manager.</b>
B Reluctant Innovator	Nil	Work shared lead partner role going into fundholding. Delegates everything but clinical decisions relating to fundholding to fund manager. Makes policy decisions based on external policy hence boundary management and protects himself from a management role with a strong fund manager. <b>LP<sub>B</sub> is not a hybrid manager nor an expert.</b>
D Guardian	Internal Expert External expert	Delegates all things administrative/managerial that relate to the internal working of fundholding to the fund manager. Does not work share with partners hence become the fundholding expert within the practice. Does not work share with fund manager. Engages in contracts and getting good deals outside the practice hence exhibits boundary management. <b>LP<sub>D</sub> is a weak hybrid manager and an internal and external expert.</b>
E Opportunist	Internal Expert External Expert Public Activities	Does not work share with fellow partners. Delegates all fundholding to his reliable team. Develops personal domain becoming expert (not work sharing) within the doctors' partnership in fundholding but also an expert beyond practice boundary engaging in public activities. Boundary management via networking. <b>LP<sub>E</sub> is a weak hybrid manager and expert (internal and external).</b>
F Reluctant Innovator	Nil	Work share across all fundholders hence no internal expert. Dominant fund manager role with no work share with any of the doctors. <b>LP<sub>F</sub> is not a hybrid manager or expert.</b>
H Opportunist	Internal Expert External Expert Public Activities	Not overtly work sharing hence becoming expert within the practice. Some internal constraint from other partners. Work share with the fund manager. Delegation of more financial aspects to fund manager. Development of hybrid domain as a well as hybrid manager. Engagement in public activities related to fundholding. <b>LP<sub>H</sub> is an expert (internal and external fundholder) and a strong hybrid manager.</b>

<b>Lead Partner</b>	<b>Framework</b>	<b>Relationship with Fundholding: What they did and how they did it</b>
I Guardian	Internal Expert External Expert	Some evidence of work share of lead partner role with other GPs – they were ‘in the loop’ but no evidence of other doctors developing personal domain of expertise in fundholding. Work shares the management role with fund manager. Decision maker and external negotiator. Boundary management via networking. <b>LP<sub>I</sub> is an expert (internal and external fundholder) and a strong hybrid manager.</b>
J Opportunist	Public Activities	External expert before internal expert in IT. Partnership constrained his aspirations for a leadership role. Delegation of financial aspects and contracting to fund manager – does not work share with fund manager. Tried to make fundholding fit into his extant personal domain and expertise in IT and failed. <b>LP<sub>J</sub> is not a hybrid manager nor an expert in this analysis.</b>
L Opportunist	Nil	No indication of the development of any expertise or public activities internal or external to the organization. Delegates all fundholding to his fund/contract manager. <b>LP<sub>L</sub> is not a hybrid manager nor an expert</b>
M Reluctant Innovator	Internal Expert External Expert Public Activities	No indication of constraints. Delegates all fundholding to her fund/contract manager. Does not work share with colleague partners or fund manager but does monitor contracts. Develops personal domain becoming an internal expert (not work sharing) within the doctors partnership in fundholding but also an expert beyond practice boundary engaging in public activities (external expert). Boundary management via networking. <b>LP<sub>m</sub> is a weak hybrid manager and expert (internal and external).</b>
N Opportunist	Internal Expert	Does not work share with colleague partners or fund manager but does get slightly involved in annual contract process as well as monthly monitoring. Internal constraints and tensions between staff. He is the internal expert for fundholding. <b>LP<sub>N</sub> is a weak hybrid manager and an internal expert.</b>
O Reluctant Innovator	Nil	Lead partner in name only. Delegates everything but clinical decision relating to fundholding tot fund manager. <b>LP<sub>O</sub> is not a hybrid manager nor an expert.</b>

**Table 6.6 What doctors do in their management role**

partners do limit the lead partner choices in some cases; indirectly with limited time for the role (e.g. LP<sub>A</sub>); more explicitly by expressing unhappiness by them not being ‘in surgery’ seeing patients (LP<sub>E</sub>); and , in partnership conflict (LP<sub>H</sub>). Although demands and constraints do not present themselves as a strong factor that in itself indicates that the model is flexible enough to address the choices about being a doctor in management but recognises the limitations. It does provide an opportunity to look at management in the context and in relation to the activity in primary care rather than secondary care as noted in Table 5.4 (Fitzgerald, 1994).

### 6.5.2 A Hybrid Manager Role for Some and Not for Others

All doctors in the study continue to be doctors but some combine that with a lead partner *in* management role while some do not. The explanation of the management role includes choices: the degree to which they are experts, internal or external; the work share with fellow partners; the work share with the fund manager. Each practice case is examined and summarised in Table 6.6 and a new set of generalized statement about how they enact the management role can be made:

- Strong hybrid managers work share with the fund manager and engage in boundary management with involvement in contracting (for example, LP<sub>A</sub>, LP<sub>I</sub>) and develop activities related to fundholding outside the organisation. They are truly active in the management of fundholding and are a doctor/manager. Some strong hybrid managers work share by consultation with other partners (LP<sub>H</sub> and LP<sub>I</sub>) but do not actively share the role.
- Strong hybrid managers enact their role by work sharing with the fund manager and being the expert in the practice (internal) and an external expert. Three of the four strong hybrid managers develop the personal domain by getting involved in activities outside the organisation and in doing so are involved in boundary management to ensure operations within the practice are not disrupted, or rather, operations run smoothly and the practice is protected.
- Weak hybrid manager gets involved beyond the unit domain and some get involved in contracting (LP<sub>D</sub>, LP<sub>E</sub>, LP<sub>N</sub>) but do not work share with the fund

manager. A key characteristic is that they delegate work to the fund manager. In some of the existing research (Chapter 5), the delegation would have been recognized as polarisation (Jacobs, 2005), the creation of a dichotomy between the management role and the profession of doctoring through delegation of tasks. However, the analysis of actual enactment of the role provides evidence that it is more complex than that for doctors in management. It supports the earlier suggestion that Ostergren (2009) was wrong in assuming that devolving responsibility means less hybridisation. It depends on what is devolved and the relationship choices made relative to developing the personal domain (Figure 6.2) hence the possibility of strong hybrids and weak hybrid managers. They are still engaged in management working with fund managers, for example to achieve the objectives of fundholding for the practice. These doctors are engaged in management across the practice boundary rather than inside fundholding itself.

Further, weak hybrid managers may take two forms:

- They delegate everything bar the medical internally (the functionality of their professional arrangement) but engage in contracting and become internal and external experts. They are seen to be key figures both within and outside the practice in fundholding; or
- They do not become experts in any form and get involved for the ‘high’ created by some facet of fundholding e.g. contract and deal making and use fundholding solely for the development of their own personal domain and appear intrinsically selfish .

### **6.5.3 Links between Reasons for Going Fundholding (Lead Partner Types) and the Hybrid Manager Roles**

There is only one doctor (LP<sub>0</sub>) who continues as lead partner in name only. The other GPs all continue in some management role. This section will consider if the three types of lead partner influence the type of hybrid manager *in* management. The aim is try to identify the factors that are part of the level of engagement. It may not present cause and effect but it will provide insight into engagement in management.

### 6.5.3.1 Guardians

Each guardian retained their expertise when fundholding went live and were experts within the practice. Two of the three were strong hybrid managers who work shared within the practice with the fund manager. Work share was an indicator that the doctors were managing inside and outside: inside with day to activities with the fund manager rather than just interacting with data (Table 4.8); and outside, beyond the boundary of the practice, engaging in contract negotiations and boundary managing to protect the practice.

All three guardians do not refer to any partnership constraints (fellow GPs) internal or external which might impact on what they did and how they did it. Generic constraints of time and information systems did warrant a mention though particularly for LP<sub>A</sub> who presented a sense of wanting to do more in the new management role but not having the tools to do it. LP<sub>A</sub> and LP<sub>D</sub> showed no reluctance, indeed the former confessed he liked being involved in management as lead partner. LP<sub>D</sub> and LP<sub>I</sub> were also exhibiting a keenness for entrepreneurship and the business side thus whilst not necessarily keen on fundholding it did enable them to act out their desire to be involved in the business side of general practice, rather than being merely a doctor. Thus guardians were not reluctant managers which is a key finding to add to the literature (Table 5.4).

The three guardians also extended the personal domain of being an expert and sharing work by engaging in activities relative to fundholding outside the organisation. Particularly for Practice I, fundholding became embedded in the practice unit domain (Appendix 4 key quote 4) and the lead partners' personal domain but not through a personal domain developing via engagement in public activities. Unlike LP<sub>A</sub> it seems LP<sub>I</sub> was engaged in maintenance of the practice and his personal domain rather than innovation. This contrasts to LP<sub>A</sub> who sought innovation but was constrained by systems and LP<sub>D</sub> who innovated through deal making activities.

<b>Lead Partner</b>	<b>Class</b>	<b>Type of Hybrid manager</b>	<b>Public Activities</b>
A	Guardian	<b>Strong hybrid manager and an expert (internal and external fundholder).</b>	<b>Yes</b>
D	Guardian	<b>A weak hybrid manager and an internal and external expert.</b>	<b>No</b>
I	Guardian	<b>Strong hybrid manager and an expert (internal and external fundholder).</b>	<b>No</b>
B	Reluctant Innovator	<b>Not a hybrid manager not an expert.</b>	<b>No</b>
F	Reluctant Innovator	<b>Not a hybrid manager not an expert.</b>	<b>No</b>
M	Reluctant innovator	<b>A weak hybrid manager and expert (internal and external) but originally not a hybrid manager.</b>	<b>Yes</b>
O	Reluctant innovator	<b>Not a hybrid manager not an expert.</b>	<b>No</b>
E	Opportunist	<b>A weak hybrid manager and expert (internal and external).</b>	<b>Yes</b>
H	Opportunist	<b>Strong hybrid manager and an expert (internal and external fundholder) and a</b>	<b>Yes</b>
J	Opportunist	<b>Not a hybrid manager nor an expert in this analysis.</b>	<b>Yes</b>
L	Opportunist	<b>Not a hybrid manager nor an expert</b>	<b>No</b>
N	Opportunist	<b>A weak hybrid manager and an internal expert.</b>	<b>No</b>

**Table 6.7 Lead Partner types and hybrid manager roles**

Notably LP<sub>D</sub> was classed as a weak hybrid manager. What LP<sub>D</sub> sees himself as (Table 6.5) and what he actually does is in conflict and is reflected in a comment that implies a lack of concrete behaviours and the communication between the lead partner and fund manager as a ‘natter’. He presents himself as an expert but engages in boundary management without sharing work with the fund manager.

Overall guardians, negative going fundholding, and with little fellow partner competition for the role become experts and are less likely to work share with fellow partners. They become internal and external experts as they boundary manage to protect the practice. Some, not all, engage in public activities that strengthens their personal domain. The guardians that work share with the fund manager are classed as stronger hybrids because the lead partner activity indicated by interaction with data means a stronger internal practice role in management. They may delegate but they also use the information in their new expert role.

### **6.5.3.2 Reluctant Innovators**

The reluctant innovators were lead partners from practice B, F, M and O. All of the reluctant innovators did not engage in day to day activities beyond going fundholding (Table 4.8) and only LP<sub>B</sub> interacted with the data from the fund manager (monthly) – the rest less frequent, even annually. From this analysis using the framework (Table 6.3) LP<sub>O</sub> was the most remote from any function of fundholding, administrative or management based, yet in the perception of his own role he was close to fundholding (see Table 6.3).

Three of the four reluctant innovators were not hybrid managers in fundholding. Based on the criteria in the framework of analysis they did not engage in management but polarized by delegation. There are differences in how that polarisation emerges and may be explained. LP<sub>B</sub> was work sharing with other partners before fundholding and had a strong practice manager/fund manager which may have influenced engagement in management (see Figure 6.5); that is, deterred engagement. Indeed a dominant fund manager is also identified in the case of LP<sub>F</sub>. However, one cannot conclude if the fund managers were selected to avoid engagement in management by GPs or were a factor that influenced its failure to happen. One can say it is likely that fund managers would not encourage engagement in management by GPs if it was their expertise, consistent with Kurunmaki (2004) who observed in hospitals that doctors were more likely to engage in financial argumentation in the absence of the expertise of an accountant. On the other hand, LP<sub>M</sub> moved from not being a hybrid manager to a weak hybrid managers as her views of management were mollified,

perhaps influenced by her external expert activity and increasing development of the personal domain. However, it is notable that this doctor engaged in public activities as part of expanding her personal domain and that those activities were not confined to fundholding. Public activity does seem to contribute to engagement in management or the engagement in the public could be part of the transition to a stronger hybrid manager as the individual becomes more expert.

All four of the reluctant innovators were keen delegators to the person charged with the fund manager role, later LP<sub>M</sub> for other reasons, the interview indicated that as she gained confidence she delegated not because she was reluctant but because of the confidence in the fund manager. These lead partners, other than LP<sub>M</sub> were delegating the expertise that they might have chosen to develop their personal domain. They did not choose to develop personal expertise in fundholding and chose not to engage in public activities. The exception was LP<sub>M</sub> who was already career building a personal portfolio of expertise and being lead partner was only one element of that external portfolio.

For those not choosing a hybrid manager role there is further explanation of why they had no role at all in fundholding. LP<sub>M</sub> concerned herself with thoughts on health policy, whilst at first denying any engagement in the management of fundholding. However, the level of concern with policy did take LP<sub>M</sub> into a more external public activity role, for example, with the Community Health Trust. Two of the three reluctant innovators ventured into some sort of engagement with policy (LP<sub>B</sub> debated the public/private sector; LP<sub>M</sub> a strong contracting function for the locality, that is beyond the practice boundary). Reluctant innovators were typically from practices that went fundholding for negative reasons and they headed up the initiative to protect the practice from policy initiatives with no intention of working on fundholding as part of the reform to a positive end. Thus reluctant innovators did not engage in management but were concerned with policy and sought to use policy to protect the practice and maintain it rather than to develop it. They did not actively engage in protecting the practice.

### 6.5.3.3 Opportunists

Opportunists present a full range of hybrid manager: strong (LP<sub>H</sub> -one incidence); weak (two incidences); not a hybrid manager (two incidences). LP<sub>E</sub> and LP<sub>N</sub> are weak hybrid managers. LP<sub>E</sub> is involved in public activity rather than being an expert or work sharing. Both LP<sub>E</sub> and LP<sub>N</sub> have, and place, total trust in the fund manager demonstrated through the role of accounting described in chapter 4. The over reliance and lack of interaction with the fund manager reduces the strength of the hybrid manager role as they work share less with the fund manager.

The analysis reveals that LP<sub>H</sub> was a strong hybrid manager who executes his role by working across the practice boundary, networking with other fundholders, in the interest of power relationships because of a strong single provider in the locality but work sharing with the fund manager. He was co-operating with those outside the organisation that were useful to the practice and becoming an internal and external expert. LP<sub>H</sub> also expressed a preference not to become a fundholding expert but to concentrate on his primary career as the doctor – this came across strongly in the interview but is contradicted by his own personal description of what his role is which suggested he was developing as an expert in a management role. Thus he did not wish to present himself as active in management, perhaps associating it with powerlessness and lack of respects like hospital doctors (Russell *et al.*, 2010). This was achieved by delegating some tasks to practice and fund manager hence corroborates the initial analysis that he was not active in day to day activities (See Table 6.6), however the combination of evidence of public activity and reporting to the partners suggest a more internal management role as he worked with the fund manager.

LP<sub>N</sub> (weak hybrid), on initial analysis, differs only from LP<sub>H</sub> (strong hybrid) in apparent contracts and performance management activity. However, he argued that he only entertained involvement in the ‘grand policies’ yet the evidence from the initial analysis of phase one data shows that he engaged with the fund manager on data issues on a monthly basis. Much like LP<sub>H</sub> he attributed good fund management to good contracting and fund management and that he did not get involved in it. There

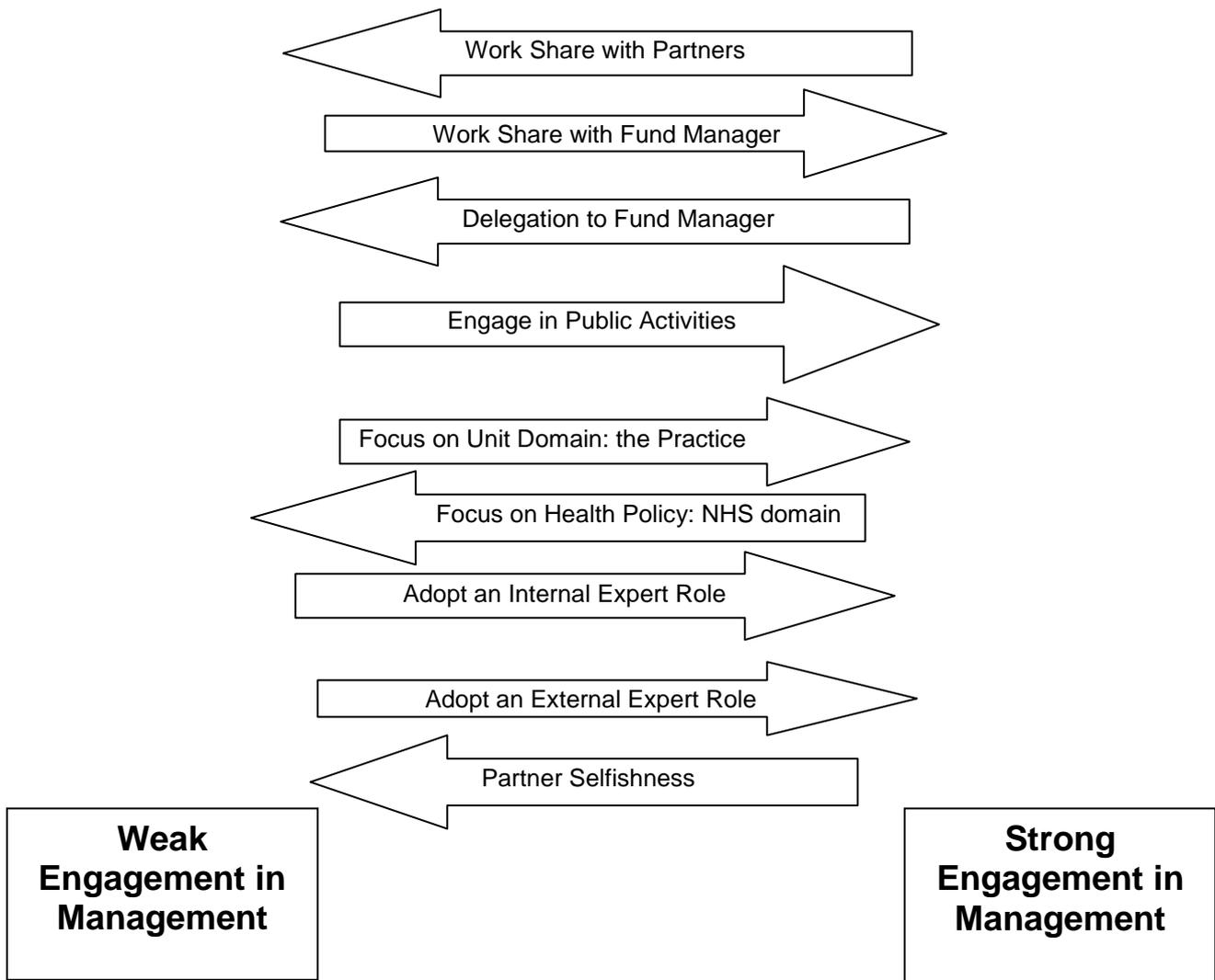
was no indication of public activities to add to or enhance his personal domain but he did keep abreast of policies, hence deemed weak rather than strong.

LP<sub>J</sub> and LP<sub>L</sub> were not hybrid managers, neither indicating work share in the description of their role, neither suggested expertise in their lead partner role, both engaged monthly with the data. The concept of work share in his LP<sub>L</sub>'s opinion stemmed from the 'we' rather than any evidence from the interview of personal activity in sharing the work. LP<sub>J</sub> did not identify any expertise on being questioned about his role but he was at the vanguard of fundholding in his locality, advising the health authority and therefore engaged in public activities. Like LP<sub>L</sub> the work share articulation was a myth as the tasks had been delegated to the contracts and fund manager but unlike LP<sub>L</sub> left LP<sub>J</sub> to develop his personal domain of expertise in IT and combine it with public activity. Both these partners were essentially relatively selfish individuals with personal agendas compared to other lead partners.

#### **6.5.4 Factors that Influence the Degree to Which Doctors Engaged in Management**

Figure 6.4 shows the factors interpreted from the analysis of the data and the direction of those factors that influence the strength of engagement in management by doctors in primary care. By analysing what they do and how they do it insights are gained on how they engage in management and the factors that influence. The strength and combination of the hybrid manager role will vary according to the strength of each 'arrow'. Weaker managers are more likely to share work with fellow doctors in the practice, be pre-occupied with broaden NHS policy and be selfish individuals. Stronger managers, share work in the management team, probably understanding it better – becoming expert and engage more freely in public activities, enhancing an expert role both inside and outside the practice while maintaining the notion of professionalism through focus in the unit domain rather than NHS policy at large.

There may also be a transient stage when engagement in public activities make doctors in primary care better, more engaged, managers at practice level, indicated by some evidence of shifts from not being a reluctant innovator to a weak manager, for example, LP<sub>M</sub>. The exertion of each of these arrows may also determine the width of the bands of choice and constraints (Figure 6.1).



**Figure 6.4 The Factors and Direction of the Factors that Influence Engagement in Management**

The literature of doctors in management is clear in the perception that there is a need for doctors in management in both primary and secondary care (Table 5.4) and that it should have a high level of relevance for the reality of the work of the doctors in secondary care (Brazell, 19870; Fitzgerald 1994). Here in primary care relevance and reality is important as there is stronger engagement in management by guardians who protect the practice domain and notion of professionalism. Management is preferred as a secondary/part-time role as in secondary care (Table 5.4). Even reluctant innovators in primary care engage more in management when certain factors are combined, protecting the practice and being less concerned with policy and more with

the reality of management for their practice. In both sectors there is an extensive literature on doctors' reluctance to be engaged in management (Table 5.4) and less so on how they are motivated or engage in management in both sectors. This study has given insights into the hybrid manager role of doctors in primary care for the first time and extended the notion of the hybrid manager by considering the factors that influence strong and weaker engagement which might be applied in both sectors in the current NHS models for engaging doctors in management. It may also be investigated for its application in other semi-public sector organisations (Noordegraaf and Stewart, 2000) such as schools. Further it has looked at management in the context of role and activity in primary care for the first time (Table 5.4) using the legacy of fundholding.

Some doctors are motivated into management in secondary care (Fitzgerald, 1994) and primary care (Cowton and Drake, 1999a, 1999b). This study has established insights into the factors that contribute to engagement in management. This has implications for other schemes that involve doctors in management and might be applied in different models of in the NHS and other organisations. It seems reluctance can be mitigated by bringing the reality of the practice into the model, rather than just educating in management techniques as a generic prescription (Table 5.4). Doctors can be enticed by harnessing their need to protect the practice domain (encompassing the patients). Further while the role of accounting is not itself important in the management of such schemes the manifestation of accounting in design via budgets presents the possibility of reporting mechanisms that facilitate work sharing with the doctor and administrative support, increasing their hybrid manager role and possibly effective in maintaining or innovating in the practice.

## **6.6 Conclusion**

The purpose of using the demands, constraints and choices model was to address the research question of how did the lead partner enact the management role; what did they do and how did they do it? The aim was to extract from the data what the interview questions did not ask directly as the emergent findings needed a more creative 'bricoleur approach' to make sense of the interview data. The evidence does

not pretend to be conclusive or generalizable but it does provide new insights to the context of doctors taking on a management role in primary care. It enables an extraction of the factors that contribute to the degree of engagement in management (see Figure 6.5) and the thesis presents new contributions, in addition to already published work, that contribute to the literature in primary care, filling the empty cells in the primary care column of Table 5.4.

Doctors engage in management in different ways and to differing degrees. When GPs were given the choice to engage in a management role other studies reported reluctance and delegation. The concept of a hybrid manager as a description of somebody in that role is not sufficient and the analysis has enabled hybridization to be explored and the development of a model of hybrid manager levels of engagement. It shows that some doctors do choose to polarize the two roles but others do not. It presents lessons for engaging doctors in management. It also supports the notion that accounting is important in the change it brings. It can help construct social order and may become accounting in motion (Hopwood, 1987). Accounting goes beyond a technical item for administration and constructs a useful fundholding organisation towards achieving the aims of NPM and facilitates doctors engaging in management.

Now it is established that hybrid managers existed in primary care and that factors have been established that present different levels of engagement in management. The study contributes to the overall doctors in management literature but can also go a step further by revealing how the careers, the personal domains, of those doctors progressed. Is a career in management sustained and how do the different types of doctor managers reflect on their management roles? The next chapter present case studies of some of the GPs and will help contribute to the comparison of secondary and primary care and the broader literature. It will help fill the gaps (Table 5.3 and 5.4) where there was little evidence of satisfier, dissatisfier and advice to others from the primary care sector when compared to the secondary care literature, contributing to the last two rows in Table 5.4 amongst other things.

## Chapter 7

### GPs in Management: A Continued Role

#### 7.1 Introduction

This chapter presents an analysis of new interview data to address research questions five and six: did lead partners continue to engage in management after fundholding; how did lead partners' careers fare after fundholding? It seeks to identify if involvement in management is chosen in primary care after fundholding ended to identify any satisfier, dissatisfier elements (Buchanan *et al.*, 1997) and to consider if doctors missed management when budgets as a mechanism were withdrawn (Goldie and Sheffield, 2001). This contributes to the doctors in management literature to provide insights and an interpretation of the impact of how a time in a role, as a 'hybrid' manager or not, can impact on the careers of a group of health professionals. Interviewing the lead partner for a second time enabled investigation of what the careers of the doctors who chose management look like and if they continue to choose management.

The first section outlines the research method for the second phase of data collection and the case studies of each lead partner. The second section summarises engagement in management beyond fundholding (research question five). The third section identifies and interprets the reflections on the satisfaction and dissatisfaction of GPs in management by interpreting their reflection on their post-fundholding careers (research question six).

#### 7.2 Engaging the GPs for a second time: Interview Design

Each of the practices from phase one where the lead partner was interviewed (eleven of the twelve), were contacted by telephone asking to speak to the lead partners to enable the researcher to identify the current whereabouts and position of the original interviewees. Six of the eleven lead partners from phase one agreed to an interview.

Unfortunately one partner had died. The remaining, four GPs, did not respond to an initial letter and in all cases at least three follow up calls were made. There were no direct refusals for interviews.

<b>GP Practice Code</b>	<b>Type</b>	<b>Interview Date</b>	<b>Location</b>	<b>Interview Length</b>	<b>Status Relative to Practice</b>
A	Guardian Strong Hybrid manager Expert	16 December 2008	Surgery	42 minutes	Semi-retired
E	Opportunist Weak Hybrid Manager	2 March 2009	GP's Home	78 minutes	Retired
H	Opportunist Strong Hybrid Manager	30 March 2009	Surgery	50 minutes	Full-time
J	Opportunist Not a Hybrid Manager	26 June 2009	Surgery	48 minutes	Full-time
M	Reluctant innovator Weak Hybrid Manager	1 May 2009	Surgery	42 minutes	Full-time with time buy out to act as PCT clinical lead in a specialist area
O	Reluctant Innovator Not a Manager	23 March 2009	Surgery	24 min	Resigned on date of interview

**Table 7.1 GP Status and Interview Data**

Table 7.1 describes the occupational status of the lead partners in the practice at phase two, the interview date, location and interview length. One GP was retired, two were semi-retired, three were full time and one GP was in 'career crisis' and retired on the day of the interview. This confirms that not all lead partners were the junior partners. The interviewed lead partners from phase one will be called GPs and denoted by original practice in sub-script for example GP<sub>A</sub>.

The interview questions are located in Appendix 2. Each case for each GP has four main sections: reflections on Primary Care Groups (PCGs); reflections on Primary Care Trusts (PCTs); reflections on career development and the highs and lows.

Compulsory PCGs were created in 1999 made up of a number of GP practices as sub-committees of the Health Authority. PCTs were established in 2002, each headed by a chief executives. GPs could be board members if they were elected to the Professional Executive Committee (PEC). The GPs in this study were asked about how they were involved in the post-fundholding era of PCGs and PCTs. It was considered too early to question about the start of Practice Based Commissioning (PBC), however, it did arise during the course of the interview and a section in each case highlights the discussion that emerged relative to PBC where appropriate. The study introduced the opportunity for reflection on job history which involved choices and decisions. Arthur *et al.* (1989) explained career anchors according to the model developed by Schein (1978) “as a way of explaining the patterns of reasons” and these were used as terminology in the interviews to guide the interviewee and provide consistency in the data on how careers had fared: technically; managerially; creatively; in terms of security and stability; being autonomous and independent. The GPs at interview struggled with the meaning of those concepts in the context of the originating model but it did help the interviewer focus the GPs. Most importantly it provided guidance and met the objectives of the fifth and six the research questions in order to conclude this longitudinal study: did lead partners continue to engage in management after fundholding; how did lead partners careers fare after fundholding?

The transcribed second phase interviews were analysed and summarised to present a case according to the interview themes: PCGs; PCTs; PBC; and personal reflections which were structured with the career anchors (Schein, 1978). The interview questions, summary and analysis of phase two interview are independent of the first phase in order not to prejudge and anticipate too much in the summary of phase two interviews. This approach would capture the essence of the new interviews which could then be analysed in the context of the primary analysis and any new key themes arising.

### **7.2.1 GP<sub>A</sub> – Guardian, Strong Hybrid Manager and Expert**

GP<sub>A</sub> classed himself as semi- retired and at the ‘latter end’ of his career. Nevertheless, the data indicated he was close to full time, working two and a half days in the same practice as phase one. Further, he was occupied for much of the remaining week (and evenings) in a large commissioning group within the practice based commissioning scheme.

#### **7.2.1.1 GP<sub>A</sub> and PCGs**

The interviewee was steered back to talking about PCGs after initially referring to PBC as he was pre-occupied with his activity in PBC at the time of the interview. He was involved early on during the era of PCGs, being the joint chairman of the ‘city wedge’ PCG, something he did not view as a good period for him personally because he did not think that he had the time to devote to it. After the onset of a period of illness GP<sub>A</sub> handed over the reins in full to the joint Chair who had “bundles and bundles and bundles of time...well it wasn’t working as two people largely because I couldn’t give the commitment and I wasn’t sure of the direction”.

For this GP the direction in which PCGs were going was not the way he wanted. He chose to step away from close involvement in the initiative. He described the direction as being overly political. Political for this GP was in the context of the number of the agencies involved in commissioning, it being more than a practice based initiative and with less emphasis on the individual practice aims, for example, the local Council and Social Services were involved which he found “pretty uninteresting”. Though active in fundholding, this GP did not put himself forward for committees in the post fundholding period of the Primary Care Group. He described the period as not making much of a difference with nothing really happening and with little identifiable benefit in being personally active in external relations between the practice and the PCG, “...couldn’t see any purpose in it”.

None of the partners in the practice engaged with the PCG over and above that involvement personally explained by GP<sub>A</sub>. However, GP<sub>A</sub> did identify some things that worked well with PCGs and on reflection, something that he enjoyed:

*...getting doctors together to talk was good. I was the clinical governance lead...I used to take that seriously...learn but don’t blame...that was*

*good, I learned, I personally learned a lot from that...with hindsight I enjoyed that... The bits that applied to medicine I quite liked but I'm not heavily into joined up management type stuff...bringing this service and that service...not what I'm good at.*

Hence, despite reservations about all the other agencies involved, negative thoughts on PCGs by this GP were tempered by personal ability to learn something new. There were indications that he became used to the idea of 'shared agreement'. Regardless of accepting this more collegiate approach, there were two areas where PCGs were viewed with reticence. Firstly, the slow process of the apparent 'management by committee' seemed to frustrate this GP as decisions were delayed. Secondly, there were issues with incumbent performance measures, "... very dispiriting...elements of judgmentalism... where you thought something should happen and nobody would actually do anything".

#### **7.2.1.2 GP<sub>A</sub> and Primary Care Trusts**

The GP said he was not involved in PCTs at all and nor were other partners from his practice. There was opportunity to be Chair of Professional Executive Committees (PECs) but this GP was not involved:

*There was a lot of reading involved in all these things and I don't get a buzz out of that, you know I get a buzz out of doing things I can directly see a benefit for my patients...some or all of them were political appointments.*

Locality managers were appointed by PCTs to manage but this GP contended that the practice never saw them. He revealed that he was the locality representative, although not part of the committee, "...it all happened outside of our practice in the sort of trust buildings...I was waiting for some change." It seems GP involvement in management was put on ice through lack of opportunity to engage in the activity of management. GPs seemed on the periphery within their practices, on the outside of PCGs, observing them but not feeling a part of the process. What motivated this GP in this PCT era was anything that influenced and enhanced at practice level, for example, citing the benefit of being able to take on another partner through central funding. It seems the centrality of PCTs enabled some practice development which pleased GP<sub>A</sub>, "...we went with it and it was very good for our practice it made a big difference".

The ability to gain a partner, at the time of PCTs, arose from the creation of fixed payments to GPs for annual provision of primary care services called Personal Medical Services (PMS) which were not compulsory, practices chose to join PMS, “I looked into that...better than not going... and we went with it, not as early as we might have done...that was about delivering extra things in our practice which was good”.

### **7.2.1.3 GP<sub>A</sub> and Practice Based Commissioning**

The GP was enthusiastic about practice based commissioning. He was immersed in the current initiative and keen to talk about it. It was evident that he recognised and seized opportunity:

*We understood and we knew that we should be involved in practice based commissioning because if you don't get involved in things you get left behind. It's not the best analogy today but the first house in the development is usually better value than buying the fourth phase.*

The GP got involved in practice based commissioning through being invited to a meeting by his previous fund manager, who had not been employed by the practice for some time. GP<sub>A</sub> enjoyed that meeting as it was “energetic and it was very well thought out” and since he was “winding down” for retirement he got involved in PBC with encouragement from others that his contribution was valuable. It seems this GP may have been winding down from general practice but not from ‘management’ and more strategic things linked to his primary career.

The earlier part of the interview was much about the energy of the people he was involved with and suggested the rest of the ‘day job’ of doctoring was either not as exciting or that he was looking for something to occupy his retirement, or perhaps a mix of both. Thus, it was more than a single individual getting involved in matters of management as the networking as part of a larger group was important. His expertise in management was recognised and he was elected to a board with representatives from multiple (but not all) practices:

*Various people spoke at the meeting...there was 50 or 60 people there, and they asked me to speak on roles and responsibilities in practice based commissioning...I struggled...somebody later described it as barnstorming. I'm not suggesting I'm that good...So we've got a lot of people on our side.*

‘Our side’ suggest something defensive about this group of GPs joining together in PBC. GP<sub>A</sub> stood for election and to his surprise was voted in ‘comfortably’ to the board of the commissioning group. A Chief Executive (not a doctor) was appointed based on his past experience as a chief executive of a PCG to run what GP<sub>A</sub> called a “very corporate group”.

*It does work well and I think everybody is interested and it is exciting and I think that’s why people are doing it.*

Surprisingly, despite being against performance targets in PCG period, this GP was active in PBC as a prescribing lead and has a mollified view of targets now as he acted as prescribing lead for the practice, “looking at what practices do and reaching targets and practice incentives schemes and things like that.”. It seems such direct participation with performance targets is acceptable when he is in control of the activity, influencing and managing it within primary care, even in a specialised role, in this case taking on the role of prescribing lead for the co-operative of 31 practices. However, for this GP, that level of involvement is clearly not acceptable when PBC activity involves secondary care, “I haven’t been involved in commissioning...other people have”.

#### **7.2.1.4 GP<sub>A</sub> and Secondary Care**

The GP was explicit that he was not involved in commissioning care. However, he had learned from fundholding the importance of good systems and the importance of monitoring referrals to ensure being correctly charged for the referral. This suggests that though responsibility was devolved he retained financial control, as Llewellyn (2001) and Jacobs (2005) had found in secondary care and Hannah *et al.* (2005) in primary care. This need to be ‘in control’; is about understanding that activity is being properly recorded in order to manage and influence for the benefit of patients. Further whilst declaring he was not active in commissioning he revealed that he had been on the board of the commissioning group and sought to influence:

*I’ve been involved in other people’s things and putting my pen’orth in about that...some retirement, but I quite enjoy it actually I have to say.*

Further the GP indicated that he was also on the board of the care group which the PCT would commission from and also a venture company for buildings and estates effectively a public-private partnership. Clearly this was a portfolio retirement!

### **7.2.1.5 GP<sub>A</sub> Personal Reflections on Career: “Some Retirement but I enjoy it actually, I have to say”**

Asked about technical developments in his career, GP<sub>A</sub> referred to IT education, internet at night and lectures and that he was able to do things better ‘in the surgery’ than when he started. On reflecting on those early years as a GP:

*I don't think I realised the breadth of general practice and what you can do. When I started it was ridiculous. I wanted to be a hospital practitioner in junior medicine ...they said they couldn't afford it in the hospital. So I resigned from it and I have to say that was good thing that I did. ..That world has now changed...we used to refer people for injections...well we do all that now. One thing that has changed...probably harder now is to find time to just sit back and listen...Technically the IT is good...now you can click on a graph and a patient.*

GP<sub>A</sub> did not regard himself as a ‘great manager’ but considered himself a good starter and poor finisher. He categorically stated that he would not be going to his retirement ‘do’ with a speech like he had heard during his period of training to be a GP where the GP claimed that: ‘I’ve used 5% of my intellect in general practice’ and will then use the rest in retirement. On reflection he did not think he would have been suited to a ‘North Yorkshire...Archers or something GP’ and that he was very lucky and loved his time as a GP. At this juncture the interviewer asked if he had enjoyed it more as a result of fundholding coming along:

*I think fundholding gave us a degree of independence that we'd never had which was fantastic...freedom of independence is what people need...but in general practice if you are able to be a part of making their own decisions it's good.*

The interviewee struggled with the wording of ‘career developed creatively’ and was helped with the suggestion with ‘being able to make a difference’. The analogy of not going about one’s business resuscitating patients but being able to potentially save a life by stopping a 20 year old from smoking was offered. Further GP<sub>A</sub> suggested that while he had been able to specialise in his career in general practice more recently it would be unusual to see patients on the back of that specialist knowledge, implying general practice had become more even more ‘general’ and perhaps in the context of the question, with less potential for creativity. However in direct response to that question:

*No. Now you can definitely do more specialising if you want to without a doubt and I've got four partners who do that as a special team who are very good. I'm a generalist I think...older GPs see most things twice...most of the rare things they've seen them...you learn ways of behaving and how to sort things out. Sometimes you haven't the foggiest of what is wrong with somebody but you know how to get it sorted and I think that's the main thing.*

On the question of career stability and financial security the GP claimed to be financially secure and in a secure job, but that projecting forward that might change for general practitioners. Independence was deemed of paramount importance particularly as 'crucial to the independence of patients' - the context of patients advocate. It was suggested that some GPs abuse their own independence and create their own agenda, that working in isolation as a risk - an interpretation supported by the GP comment that in larger practices there is some protection from such a scenario. This is an apparent reference to the 'danger' of single handed GPs i.e., embodied by the Shipman scenario. This then brought the session deeper into independence and autonomy specifically, which was immediately coupled with thoughts by GP<sub>A</sub> on independence being eroded through the work of PCTs, but a view somewhat tempered:

*I think that if you work with your PCT and try to understand their pressures, that they have, you get good management in your practice, you know how you can achieve quite a lot for your patients...Finding time for patients is hard.. I just think that's crass because the Prime Minister was embarrassed once...the people who are disadvantaged are the older people... the shovers get in now.*

#### **7.2.1.6 Changes since fundholding: practice versus GP**

The practice's highs, from the perspective of GP<sub>A</sub>, were of a singular source but with consequential benefit; fundholding savings being ploughed into buildings that "transformed care on our other surgery" through negotiation with the health authority. The lows as far as GP<sub>A</sub> was concerned were: fundholding stopping; people losing their jobs as a result; a sense of what a shame it ended because "we definitely, definitely made a difference and were poised to make a much bigger difference".

For the GP individually the new surgery was a high and it was "good fun at the time" and subsequently the number of partners increased. More recently, a salaried partner

had been employed by the practice. Immediately there was a jump to the present involvement on the PBC group committee:

*...and then I'd skip on from there, the next thing is suddenly to be involved in group with energy that's making a big difference and with few more decisions in our favour I think we'll make crucial difference to how care can be delivered and the sort of access of the area.*

This opened up the potential to ask the GP, now he had come back, at this point in his career to some form of management activity, what being involved does for him. Being part of the decision making process was viewed as being important, making rounded decisions and “if I were thought I was being an old fart I'd stop, straight away, but I don't think I am.” The lows however were being ill and the volume of work which was categorised in the interview to involve: the extent of medical audit; going on the internet to keep up to date and essentially being part of a busy practice.

## **7.2.2 GP<sub>E</sub> Opportunist and Weak Hybrid manager**

GP<sub>E</sub> retired in 2006 and was interviewed at home.

### **7.2.2.1 GP<sub>E</sub> and PCGs**

This GP's views on PCGs were very straight forward. At the onset of the PCG era he was 'relaxed' about the move to PCGs. He observed the committees made up of GPs and was positive about that involvement by GPs, but later became disheartened when those GPs who actually got on the committees, in his opinion were 'not very good'. They were “people who were more interested in politics 'to my way of thinking' and not those who actually understood hands on general practice.” For this GP there were clearly three types of person involved in PCGs: the non-GP bureaucrats; the politician GP; the hands on GP. GP<sub>E</sub> at this stage classed himself as being a hands on GP and on this personal involvement in PCGs:

*By lobbying, chivvying, by doing things my way and hopefully other people followed. I was once described by a graphologist who read my hand writing as only knowing how to do things my way and she was fairly accurate.*

He thought that the other practice partners left everything to him in respect of PCGs, a comment tinged with some bitterness on GP<sub>E</sub>'s part, in that he thought that the other partners blamed him when things went wrong. Overall he was distant in his

description of matters arising in that time of PCGs, perhaps supporting his role as an observer, rather than as active as he had been as a participant during fundholding. However, he did describe the PCG as having an advantage, compared to past arrangements, being ‘closer to the ground’ than the predecessor health authority and being more inclusive of nurses, however:

*The serious point is that centre directed medicine does not work. It is a recipe to end medical education. You know there is a health authority in Wales which is planning to see if they can do away with doctors and have nurse practitioners running primary care...they do not have the correct knowledge...don't have the breadth of general practice...cheaper but...they take more than twice as long to do any item of work... there is no business case for them.*

Through the creation of PCGs he felt “generally ignored” and painted a scene of administration and management that was made up of non-medical staff. Further he felt that he was dictated to from on high by the Department of Health with:

*dictates that came down...certainly the financial side of it was done by dictate not by agreement so that they would change the rules... rules that were arcane, were a little confused...It wasn't a major problem because you know that any GP who was running his own practice and had any business sense would use the system.*

#### **7.2.2.2 GP<sub>E</sub> and Primary Care Trusts**

PCTs were viewed with disdain by GP<sub>E</sub> who scrutinised successive developments. He saw recycling of “used-up members of the health authority and integration of people who had not really succeeded in other areas - like failed practice staff” to such an extent he thought that the vast number of GPs would not notice a difference between a PCT and PCG - ultimately the same personnel were involved. Personal involvement, beyond doctoring, continued with his involvement in an Information Management and Technology (IMT) group -voluntary and unpaid. Regardless of involvement in that group he suggested that the PCT was distinct because there was less professional (sic GP) representation on the PEC.

GP<sub>E</sub> declared that he was involved in IMT for ‘selfish reasons’ in order to drive forward the government policy on computerisation. He objected to the drive to one computer system for all which he was “not prepared to put up with” as one of the main reasons he was there on the IMT. Involvement in that committee was defensive, rather than supportive of the strategic objectives being heralded for IT in the NHS. He

did not agree to the centralisation of patient data, viewing it as dangerous and lacking confidentiality and having familial consequences in that he did not wish his family data to be on there. Therefore GP<sub>E</sub> was active in the committee to promote IT in general practice but also to thwart one central patient record in order to protect patients and family:

*I was not prepared to put up with that...suddenly the server went slow and I spoke to the PCT...and they said 'Oh yes we were in it at that time and I said what do you mean and they said 'well we were getting data down from it'. So I said do you have permission and they said 'we don't need it'.*

On what worked well for GP<sub>E</sub> in the operation of PCTs was the adoption of a computer policy, yet without the “ties and strings that they would have liked”. However at this juncture GP<sub>E</sub> digressed back to his loathing of bureaucracy:

*I was just thinking they appointed somebody at the PCT whose job it was to go round and check the notice boards in GP's surgery's to make sure that they had good information on them...it was just a notice board monitor integrated with a another job... It amused me, what really didn't work well was that the burdening of the bureaucracy...only way to get status in civil service is to have people working for you...but like a snowball...it just gathers and gathers. The man at the top has to have two secretaries, two assistants and a secretary for each of his assistants...it goes on and on and on.*

GP<sub>E</sub> summarised the PCT era for the practice as having only the benefit of improvement in IT, a system necessary, in his view, partly to meet the increasing administrative burden being imposed on GPs and partly to meet the demands placed on GPs for information and data collection. This was pursued by the interviewer referring back to fundholding; had fundholding enabled getting data together for the first time in general practice and making sense of it become useful? The GP agreed but made clear that that data was not clinical data “so much as administrative data...we bought activity and therefore it had to be monitored... couldn't trust [us]” and that data was mainly primary care data on referral activity beyond practice boundaries rather than the activity within the practice.

Reflecting on the respective role of GPs compared to professional managers at this time he described the professional managers as carrying out orders on behalf of the PCT, trying to make directives work from a GPs point of view:

*In fact they had very few original ideas...just to make us think that we had representation that was meaningful but in fact I cannot remember a single decision that they made that was actually beneficial to us and detrimental to the PCT. If I wanted something I would go for it myself, and argue with the PCT.*

This suggests that in GP<sub>ES</sub> view that PCGs did not behave altruistically ever and would not necessarily make decision that were unbiased, thus first and foremost the PCT was in control.

### **7.2.2.3 GP<sub>E</sub> and Practice Based Commissioning**

*If anyone thinks that practice based commissioning, the modern version is anything like fundholding then they live in cloud cuckoo land...I think it is a very expensive waste of time.*

No further word was said on PBC.

### **7.2.2.4 GP<sub>E</sub> and Secondary Care**

When asked about his role as a manager in the management of secondary care and how that might have changed since fundholding, the interviewee became irritated:

*You've only talked about my role, my relationship and the relationship with the general practice, to the PCGs and PCTs in terms of management. Management is an entirely different thing; management on a day to day basis is running small businesses. Take on the idea that primary care split into the surgery units and each of those is a small business and it has to be run on business lines.*

GP<sub>E</sub> pointed out that it “is very easy to lose money in general practice” and the need to take care of money in order not to make a loss. He did discuss management beyond the general meaning of managing the practice like a small business: managing the administrative stuff; managing the clinical side; taking clinical decisions; introducing practice formulary; policy management e.g. on generics (drugs) and disease groups; managing costs. For this GP involvement in management is inherent to being a general practitioner but very much compartmentalised and apparently not across the practice boundary (he was an opportunist).

### **7.2.2.5 GP<sub>E</sub> Personal Reflections on Career: Retiring to personal development**

*One thing about medicine is that you continually develop your technical abilities...things I did 40 years ago would be frowned upon now, although*

*some are actually coming back into fashion...I am a much better doctor now than I ever was thirty years ago.*

When asked about how his career had developed technically GP<sub>E</sub> reflected on how he had personally developed in the context of medicine as an evolving science and how that had led his approach to retirement and the choices to be made at that point in his career; either coast into retirement or plan to enjoy your retirement:

*...coast down...don't want to get up to date, no one is going to notice or you can plan your retirement... think to yourself I love this job and I still want to continue to do it to the best of my ability...continue the learning process and surprisingly since I have retired I actually spend more time developing my skills...lots of e-learning, I go on courses not because they are of practical use to me, but I just enjoy it.*

#### **7.2.2.6 Changes since fundholding: practice and GP**

On reflection of personal development of managerial skills the GP came into general practice with “no concept of it as a business at all”. He accidentally fell into management by a route he cited as, “when the chap that was doing the books came close to retiring, none of the other partners were prepared to take on the management.” There appears to be some confusion between accounting and data management at this point and ‘management’ but it appears that ‘doing the books’ was a foothold by which GP<sub>E</sub> could gain control of the direction of the practice. Further, the opportunity to redevelop one of the practice sites encouraged him to be involved in the management of the development of the practice, also, it was an indicator like GP<sub>A</sub> that the GP liked having financial control. GP<sub>E</sub> likes to be in control and he desperately wanted to manage the redevelopment of the designated practice site, however, that was not to be, “they (the partners) were never quite sure that I could be trusted” and to that end would not let GP<sub>E</sub> supervise the build:

*...it was a disaster because the architects were incompetent and the builders were incompetent ...mistakes that would not have been tolerated had I been allowed to do it...gradually they realised I had the skills and although it was never actually decided everything devolved onto me.*

It is apparent that this GP emerged as a trouble shooter in his career, a ‘donation’ from other partners since “when it came to hiring and firing the senior partners hired but when it came to firing they always left it to me”. However, he believed his staff liked him and were ‘immensely’ loyal for that reason and that for that reason, “I could get anything I liked out of staff.”

Fundholding was recognised by GP as a good teacher of “administrative stuff...the way to manage a business was to have good financial advice and good banking practices, further:

*In terms of career it gave me an incentive which I had not had before...I was getting a bit fed up with general practice and fundholding actually gave me an opportunity that really invigorated my interest in general practice...insights...opportunities...one of the things you could do with fundholding originally was to go on courses, management courses, some of them very silly. Also some of the concepts of some management skills something you could learn. But you also have to have some attainability – you know you can teach a monkey to play one particular pieces of Chopin but he won't be a concert pianist!*

In terms of career stability and financial security the GP spoke in the third person, for those choosing to come into general practice, in contrast to his experience of a secure and stable career, which he no longer considered it to be:

*I went into general practice, you considered it to be a job for life...you would take the little pensions at the end and go off very happily into the sunset...You know the old Japanese concept of a company made for life – it ain't so and there's far more fluidity. People move from practice to practice – people doing career portfolios. Also the concept of owner-manager-practitioner has gone.*

The interviewer pursued the topic of salaried GPs which presented reflections on what GP<sub>E</sub> would have done had he not retired (through ill health), which would have been to restructure the practice and use salaried GPs to replace partners he describe as useless. ‘Useless’ in the context of not being active as partners and therefore not working in the practice as a team and therefore already like a salaried (and expensive) partner role. Since management for GP<sub>E</sub> was very much a holistic approach to all aspects of general practice there was little sentiment for those who “contributed minimally to the management, they were effectively salaried...wouldn't even say good morning to the staff. That is not my concept of running a practice nor of being a partner”.

For this GP the potentially less stable, independent and less secure career prospects for a new generation of GPs was a “perfect model for privately owned primary care” and not something he would disagree with as if he “were ten years younger I would have done that myself because if you know you can do, why not do it”. However

when asked if he would have been as satisfied he thought not as he enjoyed the “interface with patients but I have entrepreneurial skills and would have gone into partnership with somebody who could do it my way”.

On developing creatively GP<sub>E</sub> stated that fundholding enabled him “to develop things I couldn’t have done and I really enjoyed it...the negotiating which was something that was unheard of.” It was the outcome of make savings through the fundholding scheme and ploughing back into the practice that enthused the GP. Further, the ability to influence the Trust and individual hospital departments that were “starved of money” and being “creative with money that I was saving” was a real driver which was a good lead into the career development in terms of autonomy which he confirmed fundholding had given “much more” of.

Thus this GP spoke fondly of fundholding as a pioneer would. Fundholding allowed ‘them’ to look at “innovative ways to fund and to acquire services”. In this GP’s view it enabled the formalisation of previous informal arrangements and opened up a new range of contracting such as ability to contract MRI and CT scans (more clinical diagnostics). GP<sub>E</sub> referred to areas where he had been ground breaking prior to fundholding and the difference with fundholding being he:

*...was paying for it, but that’s fine because you keep control... it doesn’t matter whether I’m paying for it out of a pot that’s given to me or the government pays it directly... focussing it though me, channelling it through me I have control.*

Thus although before fundholding he did not directly pay for activity, he was pushing the boundaries in general practice. As a budget holder it gave control. He used the example of losing control of out of hours GP services as “the biggest catastrophe... and I had control...and if there was something wrong they were answerable to me”.

Post fundholding this GP described it as “very different, we lost the autonomy we had as fundholders”. This was in the context of the hospitals and secondary care but also loss of the autonomy of the “developed relationship” that had enabled him to be ground breaking and as an opportunist. There was a new era of obeying “rules and in fact it has got considerably worse”. ‘Worse’ for GP<sub>E</sub> meant the introduction of pathways and protocols:

*...pathways for virtually every formal thing now. Which meant someone comes to see me and I know the right consultant for them is Mr X because they would get on with them; they both have ability Mr X and Mr Y. But you choose horses for courses you can't do that anymore...you cannot refer directly anyway...through a referral system...managed by clerks who decide priority.*

Post-fundholding the practice highs were the gains for patients: reduction in waiting lists; financial reinvestment of savings in buildings; a radical improvement in the working environment. GP<sub>E</sub> had proposed to the PCG to take his successful fundholding as a model and move forward through a federation of fundholding practices, with a board funded by a management fee but was “laughed at...said it couldn't be done”. Pursued on whether this was what was actually happening with practice based commissioning, he agreed that was a similar model but that he was told categorically “you can't do that in the health service and that's exactly what they are doing”. The lows were not expressly discussed but are inherent from the interview; loss of autonomy; lack of choice; inability to execute creativity.

For GP<sub>E</sub> personally the absolute low was the abolition of fundholding:

*without a proper replacement to put in place...the rapid change without clearly thinking through the consequences of that change...the increase in the patient expectation without ability to meet that expectation... not giving what patients actually want...it's what patients think they are getting but they're not...You try ringing out of hours.*

### **7.2.3 GP<sub>H</sub> Opportunist and Strong Hybrid Manager**

GP<sub>H</sub> described himself at this time as the ‘number two’, that is not the senior partner, but with the role of managing the appointments, finance and practice based commissioning. He chose to evaluate each period since fundholding as well as his roles at those periods of time. Much of the interview wandered into the GP's aspirations for PBC, indicative of how at the time of the interviews there was much reflection about the fundholding period. Involved and interested parties saw similarities to fundholding.

#### **7.2.3.1.GP<sub>H</sub> and Primary Care Groups**

During this period the GP<sub>H</sub> was the practice representative who felt it was a period in the doldrums:

*I think there was a lot of frustration because you used to remember what you had achieved, what leverage you used to have, what you might have achieved, all the statistics you had...it's been a period of frustration since. There have been changes for the better but there have also been changes for the worse.*

Frustrations were numerous: inability to do referrals to named consultants; the “distractions” of a choose and book system; weakness in the information capability of the IT which:

*...there is still infancy despite having increase in technology in hospitals and the PCT. I sometimes think the end point of what information was required – nobody really thought about that and therefore systems aren't really geared up for it.*

He was further involved with the PCG through the PEC (Professional Executive Committee) for a while until “the dissenting view wasn't always acknowledged in the minutes and I got cheesed off”. However, being “cheesed off” also inspired the GP:

*...eventually I thought – OK I'll give it a go, trying again. That was the route by which a GP might attempt to influence the acute trust...the purchase of secondary care, but I became disillusioned because I thought I was just being used as a rubber stamp...I'm not a representative of the GPs. I was appointed by you via an interview so don't quote me as agreeing to all these changes.*

This culminated in GP<sub>H</sub>'s pique and subsequent resignation at which point he claimed to have become “persona non grata”. However, with the advent of PBC he decided to smooth the path to a return to influence. Partners in the practice had specific roles including joint effort towards targets but he clearly classed himself as practice representative during the PCG period. He attributed that role to default and that the “biggest mouths... the most agitating” with the practice appreciating his role at getting to the bottom of things in his capacity as the “practice Rottweiler”.

*...so you can hopefully treat our patients but we can write constructive letters and know how to use the system correctly and when the system is sadly on occasion not delivering in a big way...know how to use the system and to get the system back on track.*

The respective role and contributions of GPs and professional managers in the work of PCGs clearly irked GP<sub>H</sub>:

*...the problem is that we've had the same manager going through ...I don't see many new faces and this is one of my concerns and agitations...they talk about NHS contracts rather than commercial contracts, they still seem very distant from the reality of their*

*decisions...just happy that if they tick boxes, hit target... what they've got to pick up on just say, there should be a clause, 'treat your patients how you'd treat your family'.*

### **7.2.3.2.GP<sub>H</sub> and Primary Care Trusts**

There were further frustrations for GP<sub>H</sub> with the advent of PCTs, although he was still involved in the PEC:

*...they changed the name of the organisation but I really didn't see any change in culture. All I've seen over the years is an increasing number of people working for them, increasing complexity, increasing number of people with job titles...virtues correct but you know, where do these people tie in? The organisation at one time had practice health visitors...great liaison, you got to know them...you trusted them and vice versa...I get a letter from them but I don't know them from Adam... There have been changes for changes sake; I haven't really noticed that it has improved the bottom line for the patient.*

GP<sub>H</sub> did not seek and was not a member of the PCT board. PCTs advertised and offered remuneration if successfully appointed. However, he supported the use of targets as it had generated improvements but that “it has become God for hospital managers”. There was concern that there had been little policy reflection on what had been good and that ultimately the imposition of targets would result in “get them or fiddle them”. A positive for PCTs was the view that they had become more “business like” but this was couched with the merger of two PCTs which GP<sub>H</sub> said was characteristic of most mergers of NHS bodies, that “they still have different cultures”.

He reminisced for lost potential:

*...one thing that did work a little bit perhaps, there was at the beginning an understanding. They understood how they worked and they understood how we worked and we are two different cultures...perhaps we are just moving apart again, and considering we are both involve in supposedly providing health provision, although we are at the front of the organisations, is amazing.*

The politics of the NHS clearly frustrates GP<sub>H</sub>, “driven by dictate and targets” with senior people in the PCT arguing that the “political imperative” cannot be ignored and therefore that there is no discussion to be had. Further irritations included having access to a personal hobby newspaper banned from the NHS web, on the basis it was linked to gambling, fuelled with the irony that he could still access sites and “learn how to grow marijuana... order an escort...”

### 7.2.3.3.GP<sub>H</sub> and Practice Based Commissioning

GP<sub>H</sub>'s comments suggested that PBC would have been the ideal progression from fundholding and regarded the period in between as somewhat of a lull in the advances that fundholding had made for general practice:

*...in some ways now we look back at practice based commissioning and it's going the same as fundholding was and you think –yes! But if fifteen years ago we did this... we had all the information and I'll say we did this fifteen years ago...you just sound like an old fogey who's going grey like I am now.*

Current trends in PBC concerned the GP due to delay in data and the quality of that data being “dubious” but after becoming persona non-grata he had begun to renew his interest with a view that PBC would become a “significant force” and thus “taking it gently at the moment”. Though proceeding with some caution this desire to become involved in commissioning was specifically stated to be due to the highly likely scenario, in his view, of their being a nominal practice budget “by which you eventually you will be judged”:

*...you are going to have to stick within your budget to a degree, and the way they are getting external providers in through Darzi, through other things...if you don't hit your budget and you're going to repeatedly over spend they'll say – 'twelve months otherwise I know a man who can'.*

Regardless of his involvement and perhaps reflected in his resignation from a practice representation role, he did not think anything worked particularly well in PCGs: a loss of freedom; elimination of the concept of savings (“never saving money by skimping on patient care – made sure they got what they needed...cost effective); political interference.

The respective role and contributions of GPs and professional managers continued to irk GP<sub>H</sub> under the PCT:

*...interesting that you use the word professional...I do feel there is a cultural problem in PCTs, they work in a very civil service bureaucratic fashion...not saying we should have health service run like Sainsbury's...but some of the things done could be improved...the quality and nature of the information...so how can they talk about being professional managers when they haven't done the data things ...send you*

*pages of facts...you want a single summary sheet...drowning in data...you need someone to get better quality knowledge from the data.*

The information was deemed inadequate and took too long to obtain, “five months to get figures from the hospital half a mile away”, and that it was often inaccurate and lacked comparatives.

#### **7.2.3.4 GP<sub>H</sub> and Secondary Care**

This was not an elaborate section of the interview. GP<sub>H</sub> referred to his direct influence with an example rather than expressing any involvement in the management of secondary care. He described an incident where one of his patients was treated very badly by a hospital and he called for an interview with the chief executive of the acute trust. The PCT wished a representative to be there but he instructed them that “they were not to contribute you are not part of this meeting... I feel sorry for the consultants, aren’t able to control own waiting lists”.

#### **7.2.3.5 GP<sub>H</sub> Personal Reflections on Career: Priority for the clinical**

The GP described his career developments in two parts, a priority for the clinical and how hard it was to keep up to date with the speed at which medicine advanced and how “the way you manage patients has been revolutionised”. The second side was the “managerial side of it – as you become more senior you take on more serious aspects of running the practice”.

He had reached the status of number two in the practice and showed no desire to be the Senior Partner describing that as a presidential role in practice H, “giving people flowers on their birthday when they leave and also has the tough thing when things go wrong”. GP<sub>H</sub> described the number two role as:

*...what I call the politics and the upper echelons of the bureaucracy with the acute trusts and PCTs...and what I’ve notice is that it has become more centralised and one can argue so care is equivalent across the country...increasingly target driven...and I do believe that managing targets is a weakness on many levels...so that it is useful but not so that it is absolute.*

Managerially the GP thought that his career had been “evolution rather than revolution...no actual formal teaching for it”. Pursued on why he chose to do it he thought it was because:

*way I'm made... I do not deal with staff, I just can't do HR, I don't deal with training...my persona...I am more business-like and that's why there needs to be a blend because someone in the practice does need to occasionally pull me back.*

In career terms of security and stability he said that he occasionally had to remind staff that “we are lucky, people know unless they are really naughty that here is a job for us here”. He pondered that GPs did have a degree of independence and referred back to consultants been ‘told’ what they will operate on further describing the discretion, for example, in participating in the interview itself. There were things to be grateful for such as the final salary pension, being able to do the right things for a family when health issues arose and being able to have other interests, in this case racecourse work:

*...you see everybody should have an interest outside just pure general practice or I should go nuts*

Rather than creative, GP<sub>H</sub> thought himself conservative:

*I'm actually quite conservative in many ways and organisational things – I think there can be too much fiddling. I do believe that things evolve, technically in medicine and also administration but you've also got to remember that every step forward is not saying will be the right step, occasionally you have to go backwards...we don't do everything...it doesn't disrupt the financial stability of the practice and it doesn't effect things in a negative way for patients.*

As alluded to throughout this interview autonomy and independence in his career were important to this GP but with caution that it could not be to the exclusivity of all else:

*...unless we tow the line to some degree somebody will be found...Autonomy I think sometimes we take it for granted and think we will lose it unless we occasionally reflect on how much autonomy we have got...I try to think of an analogy...my omelette pan at home, if anybody uses my omelette pan for anything other than omelettes and pancakes I go bananas, well there's no need but I sort of blaspheme...but you know it is my omelette pan.*

#### **7.2.3.6 Changes Since Fundholding: for Practice and GP**

GP<sub>H</sub> lamented the demise of fundholding and thought that the state of practice was currently back to “square one” despite fundholding generating a shift in quality:

*...out of the hospital to a private provider...revolutionised the service in terms of quality...galvanise the acute trust to get act together and we got a new consultant...we handed the service back to them.*

The lows for the practice stemmed largely from irritation with the system: rearranged appointments and subsequent patients that get lost in the system; perpetual bed crisis as the system runs on too high occupancy with no slack in the system; running a system based on average which means “half the time you won’t get it”.

For the GP becoming persona non grata was a low:

*I’ve got to be careful...from being very much on the inside...to be very much on the outside...someone to be guarded against, and it was a pretty uncomfortable time.*

The highs:

*I think the highs don’t come from the administrative side of it, I think the highs still come from the clinical side of it.*

The clinical side was talked about in the context of a holistic approach with a lengthy example that if a patient has dementia then the statistic on their cholesterol is not significant to the general practitioner, but whether or not their wife is coping is, and helping through organisation of respite care. It was evident that interaction with patients was important:

*There’s some doctors who will find that they are more comfortable taking a managerial role than a clinical role, that is fine. In some ways I feel sorry for them...I think they’ll miss out a lot because there is an incredible buzz from making a diagnosis...managers can say you didn’t advise properly, and if you think better you can come and do it, and if when we start doing the management they’ll say well you should stick a doctor in...I think sometimes the NHS is not ruthless enough in getting rid of its less effective managers...effective not efficient...the NHS does not attract high quality managers...basically hospital managers should not be telling me what to do...they should be saying, here are the facilities which we run for you, now do it.*

#### **7.2.4 GP, Opportunist and Not a Hybrid Manager**

This GP was working full-time in the same practice. He had been renowned for setting fundholding up in the county and had a reputation for being outspoken and difficult, not least amongst his peers.

#### 7.2.4.1 GP<sub>J</sub> and PCGs

In terms of PCG committees, GP<sub>J</sub>, thought that the younger GPs who were active in fundholding did get involved, having put themselves up for election (suggesting he did not) but views “changed once they got on...because they got told they had corporate responsibilities for the decisions made by the PCG”.

After some thought the GP succinctly described PCGs “didn’t really work” for this GP; “we had no control over anything at all”. During this time GP<sub>J</sub> was Chair of the Local Medical Committee (LMC), partly responsible for working with the healthcare authority with the role of bringing PCGs in the area together. Regardless of this opinion he was able to cite the only ‘positive thing’:

*...what we did manage to do at that time was to actually get all the GPs united, sufficiently united to form our own on call co-operative which was interesting and an exciting time...co-operative worked extremely well indeed...GPs I would say were management leaders... used it as an opportunity.*

Asked further about his role in management at that time he declared he had not been involved in management but he had an appointment at the Health Authority as “Non-Executive Health Director”. There was a ruling that prevented him from taking part in PCG management as a consequence of being in that role. But he was able to influence in that role by being “the bad penny, able to ask the awkward questions”. The interviewer asked if it was good to be that bad penny and this revealed:

*...there won’t be many for very much longer because GPs are not being trained in the same way they were...they are just coming into it for a job and they are prepared to be managed. I don’t know how they’ve managed the sea change but the profession has changed so much...I mean I’ve watched colleagues of mine going into management and change from being GPs into being managers.*

However, the sea change was not as mystical as it might seem as the GP believed that civil servants had set out to ‘manage the profession’ and since they had the power it became an inevitability. On being asked what keeps them as managers:

*They lose a lot of their independent thinking...the old thing from a dinosaur like me is that GPs are capable of being independent thinkers and that’s what fundholding gave us...it gave us the opportunity for mavericks...needed otherwise things never move forward.*

As far as the practice went no other partner took on a management role, “not that it was a spent force, we just didn’t see any changes from the PCG”. There was some reflection that the other PCG had fared better “financially speaking” because it had the mass of maverick GPs and hence patients benefited from better services. In effect he thought the “whole thing was a shambles quite frankly. We did manage to preserve some of the fundholding management structures”.

#### **7.2.4.2 GP<sub>J</sub> and Primary Care Trusts**

Primary Care Trusts instilled anger in this GP. It was clear he wished that those structures created by fundholding had been preserved, at least those that were GP focussed. Asked about roles and contributions of GPs and professional managers he became belligerent “none of the personnel changed... none of the personnel changed...they sacked us all”. He described himself as being angry at the time at the “final dismantling by the new administration of anything that had gone before”. Other partners still did not engage with the PCT, and generically “they were trying to dilute the medical profession influence on Primary Care Trust and put in so called other professions”. What were the other professions? He could not be sure as he:

*...Wasn't close enough to the management situation at that time. I'd moved out from the LMC Chair and I was on the Health Authority and effectively persona non grata because the audit committee on last refused to sign them because they changed the accounting method, the deficit no longer showed.*

Thus as a non-executive director on the Health Authority and member of the audit committee he had refused to sign off accounts where a deficit had been eliminated due to an accounting policy change.

Referring to ‘management’ as a third person, “from the management point of view things are beginning to work well with PCTs” however he considered that it wasn’t evidenced based medicine but a ‘knee-jerk’ approach which inevitably meant, for him, that they would run out of money.

*We get driven down the quote ‘evidence based medicine’ level. I’m treating individuals. I don’t treat herds and a lot of the evidence is to do with herds...now I am fast becoming one of the vanishing breeds of GPs I think ... I’m a little bit worried about that...when I become infirm I don’t want to be treated according to a list of drugs.*

Further he pondered on the historic introduction of these ‘guidelines and the assurance at the time about what they were:

*...you don't have to follow them, they're not like railway lines, they're only guidelines... they now say 'shalt' and 'if thy don't thy shalt not get enough money to pay thy staff'. I think over the next few years there will probably be general practices going bankrupt, certainly going out of business...independent GPs will disappear completely, we'll all be salaried and we'll all be employed by large organisations.*

Asked to summarise what he and the practice got from PCTs, the answer again was ‘not a lot’ with himself ‘more cynical’. On the respective roles and contributions of GPs and professional managers he ascribed GPs as coming out of managerial roles linked to medicine and into PCT managers but that a mix didn’t work and referring to one GP; “he’s a director not a medical GP any more”.

#### **7.2.4.3 GP<sub>J</sub> and Practice Based Commissioning:**

The GP described himself as enthused about PBC initially and “we saw it as fundholding without the benefits of fundholding” but as the wrong person to get involved. He was not involved and suggested that I should speak to a colleague who was a chairman of one of the groups. He seemed to have lost interest when his plans for PBC were ‘stonewalled’ and he was told he was unable to do things that he wished.

#### **7.2.4.4 GP<sub>J</sub> and Secondary Care**

*In the management of secondary care? I haven't been involved as a manager in the management of secondary care since 1980 when I was on the committee. We had less and less influence over it...hospital colleagues are being managed...we are less and less able to have as much contact as we used to with our hospital colleagues and therefore we are referring to people we don't know...what about doing this for a patient or what about doing that for a patient. It's not easy to do that anymore.*

Thus for this GP, committee membership is construed as being involved in management. Although he said he was not involved he had further comment on the evidence based route and the drive for the profession to take that road, “thou shalt not do that, and... it’s easy to become a technician”.

#### **7.2.4.5 GP<sub>J</sub> Personal Reflections on Career: “Well it peaked around about fundholding...I feel less secure now than I ever have done in my entire life”**

This GP was clear that fundholding had been the hiatus of his career and the point at which he had been most creative in his career followed by “gradual burn out or big bruise on forehead trying to batter through and knock some sense into people”.

*Creatively?...during fundholding...I probably listened to my patients more than I used to...but I think I listen more now, because that’s all you can do for them. Your clinical options have been cut down.*

How career had developed technically was taken ambiguously and narrowed down to medicine but he was adamant that he carried on treating patients as he always did, implying the protocols of evidence based medicine were not his modus operandi. When pursued on that; “Yes well it is just another management tool isn’t it?” and on the managerial reflections on career he thought his career had not developed but it seems he meant to the current point as he clarified that it ceased when he left the Health Authority Research Ethics Committee. The latter was another revelation of his involvement on committees.

In terms of career stability and security GP<sub>J</sub> regarded the present as the lowest point of his life primarily because:

*I am uncomfortable because of my attitude towards general practice...I am an individual and I don’t necessarily fit into the mould...one of these days I might not have a good appraisal and that will give me problems towards validation.*

In context the comment hinged on being appraised by a younger GP and receiving complaints for decisions he’s made that were “attacking” him.

#### **7.2.4.6 Changes Since Fundholding: Practice and GP**

GP<sub>J</sub> described fundholding as driving the NHS which was not optimum from the point of view of the managers who “couldn’t control it”, politically it seemed the Conservative government devolvement to local control was favoured by fundholding but abolished under the Labour administration, driving towards “bureaucracy, bureaucratic control”. Issues for and changes for GP<sub>J</sub> since fundholding accumulated throughout the interview and some are intertwined in other parts of section 6.4 such as

a gradual move away from committee involvement and his disparaging view of evidence based medicine, further with the onset of the era of PCTs.

*We has a perfectly good system... they changed the out of hours business with a new contract...we lost 24 hour responsibility, changed contracting local GPs on call which was run by local GPs for the local population... the [our] tender was not accepted...The only group I still desperately try to maintain continuity and care with are patients of mine who are dying and I will give them my mobile phone number...Unfortunately the population as a whole are not aware of these changes all they can see is 'OK can I now get an appointment at the doctors on a Saturday'*

With a more direct question on changes it was evident that the GP separated the hiatus of his career from a more generic view of fundholding as he recognised the system as divisive. However, some of the changes were more linked to what he described the 'hobby horse' of things he disliked such as disposable instruments and towels and the lack of evidence regarding reducing infection alongside a concern with the cost relative to non-disposable items. Additional "regrets" were the loss of partners under the new system (which he thought would not have occurred had fundholding remained) through personnel issues and an inability to embed and get approved a clinical software system designed by GPs with amplified concerns over the central server system being currently proposed.

More recently a significant low for GP<sub>J</sub> was at the start of PBC, although he had been enthused about it

*We saw it probably as fundholding, more complete but without the benefits. In other words we didn't have a much freedom to move the money around. I'm the wrong person to speak to, my colleague was the Chairman of a large PCG he took over from me... I just got so peed off...the mind-set of the people [at the] PCT stonewalling.*

### **7.2.5 GP<sub>M</sub> Reluctant Innovator and Weak Hybrid Manager**

At the time of the second phase interviews, GP<sub>M</sub> was working in the same practice on a full time basis. The practice continued to share premises with another practice although by phase two both practices were in purpose built premises.

### 7.2.5.1 GP<sub>M</sub> and Primary Care Groups

Post-fundholding, there had been a decision to split the city into four PCGs. There was a strategic decision needed by the practice, to either go with a city PCG or one of the geographical PCGs:

*There was quite a lot of argy bargeing about who was going to be in which group at the time, quite a lot of manoeuvring...we thought with our expertise and management going in with x (was a good idea)...with a strong position to provide services... (however) less organised, problematical, lots of single handed GPs, so in the end we chose to go with Y.*

At that point in time GP<sub>M</sub> was on the “sort of steering committee” but the practice that premises were shared with had a GP who decided to stand against GP<sub>M</sub> resulting in a split vote which resulted in her “not having much to do with it after that”. She confirmed she had wanted to be involved and seemed sad that she had not achieved that through personal involvement at committee level. She attributed a link between practice sizes and GPs getting on committees, primarily because it was one vote per GP, thus the larger the practice (“some very powerful practices at that time”) the more votes a GP from that practice would obtain and hence the link between large practices and GPs from large practices being committee bound.

The practice of GP<sub>M</sub> is in a socially deprived area and the role of advocate was apparently stronger, or articulated as such, for this GP than some of the GPs interviewed in phase one and two:

*They were motivated and they were political animals and they wanted to do it...some practices just aren't bothered and only moan when things go wrong. I wanted here to be represented because we serve a very deprived population...make sure our patients get a fair crack of the whip... And I think that if you're not in there fighting for them sometimes it is easy to forget people because they are not middle class and articulate.*

Not being involved therefore seems at odds with the role of advocate however it could also be explained in that the practice itself was not ‘in favour’ during the PCG period. Any innovation gleaned from fundholding had been suppressed or dismissed. GP<sub>M</sub> described a wide range of services that had been generated and operated effectively for the practice population however it had been led by two ‘maverick’ GPs which had been dampened by external agents with the introduction of:

*...more and more paperwork and more and more clinical governance which is a good thing in many ways...So we stopped doing all that and*

*then converted things into more social stuff so we got the healthy living centre...increased mental health team provision so we sort of moved things round.*

In respect of who got on committees it was suggested that it depended whose 'face fitted' at any point in time and with the practice out of favour, practice M's faces 'did not fit' and there was no committee involvement.

#### **7.2.5.2 GP<sub>M</sub> and Primary Care Trusts**

With the advent of PCTs came new staff within the PCT and GP<sub>M</sub> thought that the practice collectively fared better, however the practice had shifted considerably from what GP<sub>M</sub> called a 'medical model' to a 'social model' supported by PCT with which there was a much better relationship and further:

*I do have a roll there now and in the district as clinical lead for xyz...get paid at the moment...job share but my buddy decided to resign due to pressure of work... so I'm left, yes, doing an impersonation of a headless chicken, which is quite exciting and I also do a session in psychiatry.*

The GP was asked how she became involved in delivery of this specialist secondary care and it arose from having been on a steering group in that specialised clinical area. She was approached by a manager to get involved which has culminated in further study and professional study for this GP. The further study is in the area of management including leadership, service re-design and change management. On who got on PCT committees:

*Guess what – same old! Although there was a little bit of a shake-up. To be fair, this PCT is committed to clinical engagement...do have a number of clinical leads...and we've got a sort of line manager that looks after us all and makes sure we are doing our bit.*

Thus although not involved in committees, there was participation at clinical lead level. None of the other partners were involved in committees. GP<sub>M</sub> interpreted committees in the context of clinical leads within the PCTs, all of whom are line managed by a manager in the PCT who looks after the clinical lead group. GP<sub>M</sub> was asked if it was more integrated and supported than when fundholding:

*I think the clinical governance stuff and support for clinicians is better. I mean I work very closely with the commissioners now...we talk to each other I know what they are expecting, what they're wanting and you have to be corporate to a certain extent... but they do take on board what you advise.*

Despite a recurrent theme about clinical governance being a good thing, arising from that approach GP<sub>M</sub> did not feel trusted and found it sad that so much auditing of her as a GP went on, “taking clinical governance to the nth degree, just in case”. In terms of what worked well in PCTs GP<sub>M</sub> considered that care was improved through that mechanism of clinical governance.

For GP<sub>M</sub> there was concern about the level of staff at the PCT which was also linked to her personal issue of ‘trust’:

*One concern...a lot of that has come from central...they don't always join the commissioning, the contracting and the clinical engagement and they clearly don't talk to each other... They're so busy making sure that we tick all the right boxes and do you know lots of bean counting... I don't think they trust us. I don't feel trust as a clinician particularly which I think is very sad...you've got that many people coming in and auditing you and you know messing about...*

Despite reservations and lack of ‘joined up thinking’ from the bodies that disseminate the rules, GP<sub>M</sub> was positive about what clinical governance had achieved overall, reporting that in terms of performance management, at least for under achieving practices, it should have improved care and was therefore contributing to ‘good care’ overall. In summarising the positive and negatives for GP<sub>M</sub>, the negatives were the bureaucracy but appreciating that it was dictats to the PCT that they were simply implementing. The second overall negative for PCTs was the lack of appreciation that ‘ten grand, wow, big deal so what, but to us it could make the difference between over drawn at the bank or not’. Numerous other financial irks were mentioned but overall GP<sub>M</sub> thought she managed it, “I have to go through the budget line by line”.

For GP<sub>M</sub>, personally the PCT facilitated involvement in a specialist area where she became clinical lead which enabled “service re-design, sort the pathway out... a vision which locally is healthy ambitions for mental health”. This prompted the question, was this as exciting as fundholding or better?

*Not from the practice's point of view, fundholding was more exciting, because you felt that element of control. You had autonomy and if stuff went wrong you could pick the phone up and say “I'm not happy with this and what are you going to do about it” ...now you don't have that sort of power as a practice at all.*

With that control came power for the practice who could threaten to move contracts if there was discontent with providers for whatever reason. GP<sub>M</sub> had implied that it was as exciting personally for her in her current role.

### **7.2.5.3 GP<sub>M</sub> and Practice Based Commissioning**

GP<sub>M</sub>'s practice was part of a PBC alliance which was, in her opinion, a good vehicle for obtaining "the extra stuff" which could be more people and other funding through 'new' services. Later, she reflected on the weaknesses of PBC relative to fundholding.

### **7.2.5.4 GP<sub>M</sub> and Secondary Care**

This question was omitted in error during the interview

### **7.2.5.5 GP<sub>M</sub> Personal Reflections on Career**

GP<sub>M</sub> had wanted to be a GP but was unable to obtain a job after training because there were 'too many GPs'. After a period in waiting and missing a couple of GP posts she was eventually successful with the present practice "full time and I just did surgeries...nine surgeries a week". Now that is five surgeries because of the other activities which include the clinical lead, specialist surgeries and also chair of the attached health living centre which is part of the practice premises. In addition "the sort of management stuff" such as personnel.

Technically the GP identified her specialism as having developed alongside having "learned a lot of clinical management prescribing stuff...master's course...and I'm an expert of Google Scholar". In terms of developing managerially and security and stability it is clear that there had been significant events affecting this small group of practices within one building. This included the death, in surgery, of a fellow GP from the alliance (also interviewed in phase one of this study), a death of another doctor and one doctor being struck off. In terms of creativity in career GP<sub>M</sub> regarded the mental health interest as "more serendipity than anything else" and that she had developed now with a "much more systematic "approach.

Autonomy and independence had been mentioned throughout the interview and in the context of career this GP had more to say:

*I don't think we are anymore, it's a myth. Technically we are independent contractors...more from a tax point of view, so we're self-employed...we have so many hoops to go through...supply so much information and do things in a certain way...most of the time they're fine [the protocols]...I quite like the security of that...this government has made it quite clear it doesn't like GPs...renegade on lots of things and through spin made GP's look very bad...salaried GPs don't [do extra surgeries] unless you pay them extra...and because it is your business and you're a partner and you're committed and go the extra mile.*

#### **7.2.5.6 Changes Since Fundholding: Practice and GP**

During the fundholding period GP<sub>M</sub> observed the practice getting more services in house and greater creativity which got services closer to the patients. For GP<sub>M</sub> it was an “exciting time” in the practice history as they were able to think “well we'd like to be able to do this and we've got this money, right we'll do that” which all ended when fundholding ceased. However, being a small practice without large ‘consortium power was considered a disadvantage at that time, not having the “big power that the bigger boys had” which GP<sub>M</sub> reflected on as being divisive. Practices that did not go fundholding, in her view, were disadvantaged, hence the divisiveness which she seemed uncomfortable with.

*It was divisive and I suppose going to a model where everybody's treated the same...same management and performance management does have its pluses. But I think in some ways it's a shame it went and yes I personally enjoyed it a great deal...the new order is better for all practices. I think fundholding benefited those practices who really took it on board and got out there and were prepared to work at it.*

Taking this latter comment further GP<sub>M</sub> was asked if it was the nature of the practice or the lead partners that drove fundholding forward successfully and categorically stated that “it's your personalities; it's your GP and your manager”.

For GP<sub>M</sub> personally she did enjoy fundholding and thought she had worked very hard at in together with the fund manager and had “felt in control...doing something personally to benefit the patients. We didn't make savings though”. The savings, which some practices had used to enhance practice infrastructure (see practice A and E for example) were not absent through lack of effort but in this GPs view “they never got our budgets right in my view, so we were never going to make any savings”. This implies that she thought there had been a savings incentive built in to the budgets, whereas the reality is that in the absence of good data from practices the budget levels

were based on chance and fortune, consequential savings of fundholding were not really linked to performance. Thus this GP saw fundholding as an incentive scheme even though unable to take advantage of it and that the ability to track patients was a bonus which when couched in the context of PBC was preferable:

*The problem with PBC is that most clinicians are apathetic about it...we go to meetings because we have to... it has done some good things – yes, we got new services but the data is appalling ...the other thing with fundholding, the systems were all set up, you could track the patients through. You knew down to the last penny what you'd spent and what you were doing...PBC even with improved IT the data is absolutely shocking...how can you act on something and save money unless you know what is happening?*

### **7.2.6 GP<sub>O</sub> Reluctant Innovator and Not a Manager**

This was a difficult interview, albeit short, for different reasons to say, GP<sub>E</sub>. This was because it emerged after a difficult and series of stunted responses that this was the day that GP<sub>O</sub> had resigned. Although responses were stunted they were thought without hesitation and resolute. For this reason the interviewer had to question further, with responsive questions to sometimes one sentence answers whilst not leading the subject.

#### **7.2.6.1 GP<sub>O</sub> and Primary Care Groups**

GP<sub>O</sub> was asked how he was personally involved in PCGs:

*...we had meetings regularly to discuss the way forward. It was by no means as hands on as fundholding ...fundholding was exciting...and to be honest I'd lost interest a little bit with it. I think the meetings I went to I felt quite depressed and down about it.*

He ascribed his loss of interest in the era of PCGs down to the degree of change that had gone on, change that he could not cope with, and “I think that it was less hands on and lost controls”. Having mentioned an alliance, that line of enquiry was pursued. It was a fundholding group alliance of similar practices that could work together during the slide into PCGs however he “took more of a back seat. I went to the meetings and sat there”. Evidently another partner came along at the time and gradually took over what GP<sub>O</sub> described as “that sort to role”. This was pursued and defined by GP<sub>O</sub> as:

*Sort of external management as opposed to internal management within the practice. So he's taken over that role, he's become a member of the LMC...goes to meetings with the practice manager.*

However GPo did note that the majority of people on PCG committees had been involved in the fundholding group, “a continuation”. He did not think anything worked well with PCGs and of particular detriment was the “lost track of waiting lists, we lost control of the actual money really”. He believed that the practice had “lost out” in being part of a PCG and that he got “nothing much at all, I don’t think I got stressed”. On the respective roles and contribution of GPs during this time he stated that “I don’t think I can put anything into words really” and the tone was wry with humour, a ‘no comment’ scenario.

#### **7.2.6.2 GP<sub>o</sub> and Primary Care Trusts**

Involvement in PCTs was still in the lead partner role, “a natural progression” and again going “to meetings but that was about it”. The partner who had become more externally engaged started “to take over more and more”. It was an opportune moment to ask about what sort of people got onto committees and if there was any significant change to the type of people that became involved during PCTs. That engagement was assigned to the “definite clique of people that got on...I think I was being a bit cynical about what went on in the committees”. This suggests that he did not assign himself to that group, or clique. Reasons for that remoteness became apparent:

*When it was fundholding everything was, or everything was to do with our practice, was out in the open, we knew exactly where we were, we knew exactly what the money situation was even though it is not real money, it was sort of virtual money, and then it was PCTs. It sort of got vague, and now it’s even vaguer.*

The interviewer asked if that meant that one could measure the impact beyond doctoring during fundholding, an awareness of the consequence of doctoring actions, that is see more of a consequence of what one was doing as a GP:

*Yes I think you could see more of what you were doing but now there’s several black bags of money and money gets transferred from various black bags to other black bags and you still don’t know what is going on.*

It seems that fundholding and the costs attached to doctoring were more transparent and of some apparent benefit and advantage. Asked what would motivate the GP to wanting to know about where the money under more current funding regimes prompted the response of “nothing because I’ve handed my notice of resignation in today”.

Thus the GP did not think much worked well for PCTs primarily because they were becoming “vast organisations” and that ultimately the practice lost out through the funding mechanism which in his view averaged funding out as opposed to moving practices on. More currently the newer PCTs were being less successful as fundamentally different organisations were being forced together.

#### **7.2.6.3 GP<sub>O</sub> and Practice Based Commissioning**

Thus the vastness of PCTs concerned this GP, more currently the newer PCTs were being less successful as fundamentally different organisations were being merged with “different financial structures and they tried to pull it all apart again,” On the respective roles of GP and professional managers he did not know much about it, although thought GPs still had opportunity to get involved “but there seems to be a big management organisation down at X Mill”:

*...people have sort of moved about and changed roles and I don't know if they have the qualifications to do those roles. So it's all management, so long as you can manage a flock of hens you know you can manage a group of GPs*

#### **7.2.6.4 GP<sub>O</sub> and Secondary Care**

Since fundholding had stopped this GP did not believe he had been involved in the management of secondary care and missed it but “taking into account what we have to do these day I wouldn't have had time now to do that sort of stuff”.

#### **7.2.6.5 GP<sub>O</sub> Personal Reflections on Career: “Fighting against a river of mud”**

GP's views on how his career had developed since fundholding was summarised as “just felt more stressful and fighting against a river of mud”. GP<sub>O</sub> professed to enjoying the patient side but “just all the management side” had gotten him down. Technically he suggested that he had “learned more stuff” and on probing he described this as a “broader expertise in everything, but not great expertise just little bits of expertise”. As far as the management side he explained that he managed the financial decisions for the surgery, in conjunction with other partners, taking the lead, but did not think he managed anything specific other than that at this stage of his career.

Security and stability were couched in terms of the resignation and retirement coinciding with his wife's retirement and "thought mmmm...yes...I've had enough". In terms of creativity he did not believe his career had developed since fundholding and on fundholding:

*...we could look at what services were available and there was also x<sup>5</sup> ...almost a poly clinic...Well! It is a poly clinic...all this stuff about poly clinics is a load of rubbish...fundholding savings were pooled...consultants came in, minor ops...the whole lot...and now it is all being dissolved.*

It was evident that the dissolution of this poly clinic was a bone of contention and sensitive for GP<sub>O</sub> to both talk about in an interview and for personal reasons.

Questioned about autonomy and independence he was pensive:

*I'm not certain about that. Probably more isolated which is the same as being independent but just a little bit of an edge to being isolated rather than being independent...*

On further enquiry 'isolation' was in the context of not being part of a team, seemingly GPs "a group of us just generally and gradually pulled out of the meetings and we're sort of seen as grumpy old men". This situation, according to GP<sub>O</sub> arose from newcomers (GPs) "coming in at the bottom, taking more of an active or pushy role". However, on reflection he contemplated that "maybe we thought we'd had our time and done what we could and let somebody else have to manage the change".

#### **7.2.6.6 Changes since fundholding: practice and GP**

The highs for the practice were moving into new build premises and the lows were illness of GP<sub>O</sub> and another partner, "that wasn't anything to do with the NHS and the PCT gave us loads of support". For the GP himself there had been no highs since fundholding, "now it's just mundane stuff", and was fundholding a high:

*Oh yes, yes...It just gave us something to do different, you know, it was exciting.*

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<sup>5</sup> Anonimised to retain confidentiality.

### **7.3 Engagement in Management After Fundholding**

The study so far has examined why doctors took a management role in primary care and uses the legacy of fundholding to analyse how doctors in primary care engaged in management. As the literature developed post 2000 the doctor in secondary care (see Table 5.4) was discussed in the context of a hybrid manager and for the first time this thesis brings the discussion to primary care. This section identifies how the GPs engaged in management by hybrid manager category in order address the fifth research question: did doctors continue to engage in management after fundholding and in the case of those who did not take hybrid manager roles did they develop such roles after fundholding? Further by asking a sixth question, how did careers fare after fundholding there may be some indication of how the factors that influenced the engagement fit with a continued or developed role in management (Figure 6.5). The analysis aims to identify if doctors engaged in management when budgets were withdrawn and if that was an element they missed (Goldie and Sheffield, 2001) which would indicate that accounting change is important (Hopwood, 1987) and Hood's implications for accounting (1991; 1995) are an important aspect in getting doctors in primary care involved in management. Aligned with the importance of accounting, manifested as budgets in fundholding, some insights may be gained on the implications of how clinicians cope with financial responsibility and retaining financial control (Llewellyn, 2001; Jacobs, 2005; Hannah *et al.*, 2005).

#### **7.3.1 Strong Hybrid Managers**

The strong hybrid managers did continue some role in management according to categories explicated by the adaptation of the Stewart (1992) framework. Both GP<sub>A</sub> and GP<sub>H</sub> had continued in a variety of management roles post fundholding both inside and outside the practice. GP<sub>H</sub> chose committee involvement in PCGs whilst GP<sub>A</sub> did not because of the over-politicisation of the process. Both clearly demonstrated frustration in their roles as PCG's functions were more central, more so GP<sub>H</sub> who was piqued by his inability to influence to such an extent that he resigned from his management role. GP<sub>H</sub> did not resume a management role within PBC as the targets (which he agreed were a good thing) were used for political ends. On the other hand, GP<sub>A</sub> relished PBC and a return to management. GP<sub>A</sub> was also in favour of targets for the practice as long as he could be involved in the activity of achieving them and

influencing outcomes but was categorically not interested in interfacing secondary care commissioning process itself but had been on a committee.

One of the key differences that GP<sub>A</sub> had compared to phase one was an acceptance of a more collegiate/ corporate approach but not necessarily involvement in that shared style. Once work share in the capacity of joint chairing arose with a fellow GP he stepped aside and became less involved in management. Also, management initiatives had fulfilled his 'next mountain' as he enjoyed learning and development. The focus on the unit domain also was important (see Figure 6.5), being happy to engage in management if it influences primary care but not commissioning. When the possibility of focus on the practice in a management role reduced then the strength of engagement was reduced. It seems the more remote the activity from the practice the less happy he was to be engaged in a management role. However, public activities and networking were still important as he enjoyed being involved with like-minded individuals in order to drive things forward.

Similar to GP<sub>A</sub>, GP<sub>H</sub> had continued to engage in management but became increasingly frustrated as some of the factors (Figure 6.5) were weakened, all of which undermined his perceived usefulness as patient advocate and ability to influence the system. Additionally he missed being the budget holder, using statistics and information to gain leverage for management. This is similar to GP<sub>A</sub> who missed the target and financial aspects and accountability which with it brought visibility. GP<sub>H</sub>'s strength of engagement was also reduced as he perceived the roles on the larger scale, away from the unit domain, as representing GPs as a body rather than the practice – 'as a rubber stamp'. This suggests that networking activities have to be linked to the unit domain and the patient; that is they must have some internal management benefit.

Thus stronger hybrid managers engagement in management was weakened by: work share with fellow professionals; lack of financial data; lack of financial accountability; lack of focus on the practice domain.

### **7.3.2 Weak Hybrid Managers**

GP<sub>E</sub> did not put himself forward for committees for PCG but GP<sub>M</sub> did and was unsuccessful. GP<sub>E</sub> was despondent about those who did on the context of their

contribution to politicisation and bureaucratisation of the commissioning process. It appears that both were unsuccessful in developing their choice of management role for political reasons within the geography of the area the respective practices operated in and lack of 'face-fitting in'. Despite not engaging in management roles beyond the practice boundary GP<sub>E</sub> was still the practice conduit between doctoring and PCG a 'lead' within the practice. GP<sub>E</sub> relinquished his external expert role as a doctor in management and found a new 'hobby' in relation to IT and the electronic patient record, concerning himself with grander NHS policy. Similarly because GP<sub>M</sub> could not get on PCG committees she chose the innovation of developing the practice into a healthy living centre which subsequently led to involvement of committee in the PCT era as a clinical engagement lead.

Similar to strong hybrid managers, for LP<sub>E</sub> the more remote the activity was from the hub of the activity within the practice the less happy he was to be engaged with that activity. As a weak hybrid manager, post-fundholding he was less involved in committees that related to PCTs and PCGS because of personal characteristics, as an opportunist he was always a maverick and opinionated – his way or the highway and models after fundholding were less practice focussed. Both weak hybrid managers sought committee roles, public activities, one in IT and the other in mental health. Although LP<sub>E</sub> sought such a role for a personal reason LP<sub>M</sub> specifically went on committees in order to influence and present the position of her unit domain in order to improve patient care, both factors a positive influence towards stronger engagement in management.

On reflection, LP<sub>M</sub> was attracted by the incentive side of the fundholding scheme and the accountability for funds and more disillusioned with PBC for which she could not track funds. Fundholding was deemed good because of good quality data which helped GPs make informed decisions. It seems that LP<sub>M</sub>, though a weaker engager in management was as much involved as the two lead GPs identified as strong but this contrast to LP<sub>E</sub>. However, LP<sub>M</sub> was a reluctant innovator and not as selfish (Figure 6.5) as LP<sub>E</sub>.

### **7.3.3 Not Hybrid Managers**

Similar to LP<sub>E</sub>, LP<sub>J</sub> was an opportunist who continued to engage in committees post-fundholding however for both LP<sub>E</sub> and LP<sub>J</sub> committee membership was about broader NHS policy (Figure 6.5), IT and ethics, rather than patient centric. They were still involved in potential management aspects but not a practice influence level. This contrast to GP<sub>O</sub> who specifically did not get involved in management roles as the lack of focus on the unit domain was missing. GP<sub>O</sub> withdrew back to the internal workings of the practice and did not progress towards a management role which is consistent with the lack of hybridisation determined by phase one analysis.

### **7.3.4 How the Factors that Influenced Engagement Fit with a Continued or Developed Role in Management**

There is some evidence that work sharing with partners within the practice is not favoured by GPs who want to engage in management, GP<sub>A</sub> disengaged from a management role after fundholding when that happened. This may be linked to the desire for an expert role as part of the hybrid manager make up and pursuing the next mountain. That expert role also seems to be supported when there is potential to develop an external expert role pursued through networking in a way that protects the practice via boundary management (Stewart, 1982). Networking does foster engagement in management as indicated by GP<sub>A</sub>, GP<sub>E</sub> and GP<sub>M</sub> the former indicating that networking with the PCT, for example, produced good management practice.

There is less opportunity to engage actively in management for the GPs in terms of the design of commissioning models after fundholding and the researcher is unable to determine if work share and delegation within the practice are key to better engagement in management. However, the extraction of themes arising from satisfiers and dissatisfiers based on the Buchanan et al. (1997) summary will give insights into work share, delegation and the financial responsibility by having asked the GPs about subsequent commissioning models and the highs and lows of fundholding (Appendix 2).

#### **7.4 The Satisfaction and Dissatisfaction of Being Involved in Management: Reflections on Career**

Whilst phase one interviews enabled the identification of the factors that characterised different degrees of engagement in management (Figure 6.5 and 6.6) and the direction of the factors that influenced the engagement in management, phase two reflection and interpretation add a further richness to the study. The questions about PCGs and PCTs enabled GPs to reflect on their career and identify what satisfied them and dissatisfied them.

The second phase of interviews reveal individual difference and allow the differences to be interpreted, helped by the terminology of Schein's (1978) model. That model was never intended to recommend a model for career development (Arthur *et al.*, 1989). Accordingly, this study does not seek to recommend a career development path for doctors in primary care but it does enable some factors to be identified that might engage doctors in management for another end. It seems that having had a taste of management in primary care as part of fundholding that all of those who had some role as lead partner, continued or tried to continue in some form. Having tasted accountability and management as a consequence of being awarded a budget the interviews encouraged the GPs to reflect on what satisfied them and what did not. The next section seeks to tabulate those factors that satisfied and dissatisfied doctor in management supported by hindsight. It enhances the literature because it is a post-fundholding analysis of doctors in management. Further it can be used to augment the missing sections from the comparison with secondary care begun in Table 5.3. Each type is considered comparing the two in each group to each other to identify: any continuation in management roles; satisfier and dissatisfier elements; reflections of career. These stories behind the GPs in management roles beyond fundholding are analysed to inform a tabulation of satisfiers and dissatisfiers of doctors in management to add to the literature broadly but particularly the gap in primary care the latter possible because of the legacy of fundholding). The summary in Table 7.2 is extracted from the stories in the case studies in the first section of this chapter.

<b>GP</b>	<b>Satisfiers</b>	<b>Dissatisfier</b>
<b>A Strong Hybrid</b>	<p>Ability to learn something new.</p> <p>Benefit for patients – high level of reality</p> <p>Influence, enhancement and choice and at practice level.</p> <p>Delivery extra ‘things’ in house.</p> <p>Keep ahead of the game – avoid being left behind.</p> <p>Getting involved in collective management with like-minded GPs - networking</p> <p>Use of targets for the practice.</p> <p>Making rounded and informed decision.</p> <p>Independent decision for patient good.</p> <p>Being part of decision making process</p>	<p>Over politicisation.</p> <p>Practice being less central to reforms.</p> <p>Management activities being held outside the practice.</p> <p>Not having enough time to do management well a part of a core activity.</p> <p>Sharing lead roles with fellow GPs</p>
<b>H Strong Hybrid</b>	<p>Leverage to achieve for patients.</p> <p>Targets to improve healthcare.</p> <p>“Good teacher of administrative stuff”.</p> <p>Incentive for and invigoration of interest in general practice.</p>	<p>Practice less central to reforms.</p> <p>Inability to send patients to named consultants.</p> <p>Distractions of headline practices such as ‘choose and book’ which made little real difference to patient care.</p> <p>More faceless administrators external to the practice and less face to face health care personnel in practice.</p> <p>Politicization of targets.</p> <p>Too much data and not enough information from the data – lack of statistics.</p>
<b>E Weak Hybrid</b>	<p>Ability to use entrepreneurial skills.</p> <p>Develop things he could not have done without it.</p> <p>“Enjoyed it”.</p> <p>Negotiating and ability to innovate.</p> <p>Developing the practice.</p> <p>Ability to influence where organisation was starved of funds.</p> <p>Autonomy.</p> <p>Developing relationships – driving things forward with like-minded people.</p> <p>Having choice.</p>	<p>Over-politicisation.</p> <p>Non- GP opportunity to contribute to new administrative structures.</p> <p>Observation of rules and regulations, pathways and protocols.</p> <p>Not being a budget holder.</p> <p>Overly prescriptive rules.</p>
<b>M Weak Hybrid</b>	<p>Fighting for patients’ benefits.</p> <p>In-house services bringing services closer to the patient.</p> <p>Being in control for the benefit of the patients.</p> <p>Ability to track patients under fundholding initiative.</p>	<p>Lack of trust from administrative bodies demonstrated by audit of GPs.</p>
<b>J Not a Hybrid Manager</b>	<p>Being able to move money around.</p> <p>Being in control.</p> <p>Ability to be creative.</p>	<p>Ideas being resisted.</p> <p>Poor management structures.</p> <p>Bureaucratic control.</p>
<b>O Not a Hybrid Manager</b>	<p>Excitement.</p> <p>Transparency of where money was being spent.</p> <p>Being part of a team.</p>	<p>Not being a ‘hands on’ and less control.</p> <p>More external focus.</p> <p>Stress.</p>

**Table 7.2 The satisfiers and dissatisfiers of doctors involved in management**

#### **7.4.1 What Was Satisfying About Being Involved in Management**

The hybrid managers, more so the strong ones, in Table 7.2 were satisfied by being able to do something in management for the patients. This is consistent with primary care (Brazell, 1987 and Fitzgerald 1994) and that management should have a high level of relevance to the reality of the primary role of the professional. Challenge and individual development feature strongly, for example learning something new for GP<sub>A</sub>, being taught something for GP<sub>H</sub>, development and enterprise for LP<sub>E</sub>, fighting for LP<sub>M</sub>. Even the non-hybrids reflected on and missed creativity and excitement which suggest that individual development is a strong motivator into management across the profession generally and the individual sectors of secondary and primary care (as noted in Table 5.4).

#### **7.4.2 Budgets, Accounting and Financial Responsibility**

The strong hybrid GPs missed targets, the weaker hybrids missed not being budget holders and even those not engaged in management missed the transparency of the financial responsibility for the money. None of the respondents emphasised financial incentive of savings per se but did refer to being able to develop the practice, influencing with financial control. The GPs clearly relished financial control because of what it facilitated them to do and be. It can be argued that above all it assisted in the governance and control of the organisation and the professional lives of the GPs. It demonstrates that accounting in situ has begun to create social order (see Table 2.1). It enabled influence and enhancement of GP services beyond the practice boundary while enhancing the notions of professionalism for the GP (Harrison and Pollitt, 1994): it reduced outside interference and created autonomy and enhanced self-regulation, thus increasing the functionality of professional arrangement; it increased occupational control by giving the GPs more congenial working conditions both physically and mentally, the latter through choices; it supported autonomy and increased the illusion as they felt more in control and proactive when costs and referrals were tied up in contracting.

#### **7.4.3 Dissatisfiers for the Doctors Involved in Management**

What comes across strongly in terms of dissatisfiers is that engaging doctors in management may be weakened when the scale of the entity to be organised is too

<b>Evidence from Buchanan et al. (1997): Evidence from Secondary Care</b>	<b>Existing Primary Care Evidence: Literature Review</b>	<b>Evidence from this Study in Primary care</b>
<b>Tensions</b> develop between professionally representing colleagues and managing (overriding them).	<b>Tensions:</b> No evidence but lead GPs worried about it (Newton <i>et al</i> , 1993). Lead partner practice role did not differ to the pre-fundholding role.	<b>Tensions:</b> Not in the fundholding practices. Phase two indicates that not being able to influence when other could by being on committees created tensions across the GP community. Work share of management type roles for GPs reduces engagement in management.
<b>Defensive engagement:</b> no sense of purpose or ambition for management	Common that it was not purposeful engagement, e.g. Ennew <i>et al</i> , (1998).	Lead partner types analysis: guardian; reluctant innovator; opportunist
<b>Lack of clear definition of the role and lack of management training</b>	Fundamental characteristic of the implementation of the scheme.	Fundamental characteristic of the implementation of the scheme. The choice and freedom to devise administrative structures and teams within the practice encouraged engagement in management.
<b>Management as a necessary burden; a position to be handed on</b>	Disgruntled at management role e.g. Greenfield and Nayak (1996). Concept of the 'next mountain' Glennerster <i>et al.</i> , (1993).	Those identified as hybrid managers sustained their role as far as the regimes post-fundholding would allow. Hybrid managers were less influential in achieving management roles in new form PCGs/PCTs and found other 'hobbies' when the factors that influenced them were weakened.
<b>Influence on the hospital management process was limited</b>	No evidence of driving the other partner's decision making in general practice process either clinically or managerially.	No evidence of driving the other partner's decision making in general practice process either clinically or managerially. However, involvement in protocol and pathway audits by those in more management roles did cause some tensions.
<b>Satisfier elements:</b> access to information; problem solving; contribution to service development	No analysis or indicators.	See Table 7.2
<b>Dissatisfier elements:</b> unrealistic targets; paperwork; time pressures	No analysis or indicators.	See Table 7.2
<b>Advice to other:</b> Don't do it; understand the time pressure; have prior management training; delegate; get good support; establish voice on hospital board	No analysis or indicators.	

**Table 7.3 Comparing Primary Care Evidence from the Literature to Secondary Care: evidence from this study of doctors in management**

large, not just because of lack of lead roles but because GPs do not seem to like to work in shared lead roles with fellow GPs. GPs do not like group representation in matters that cross into the practice boundary and refer to over-politicization and less practice based reforms. This contrasts to fundholding with smaller units, being in control of the practice domain with networking beyond the practice boundary. Further dissatisfiers reflect the opposite of choice as there is more prescription after fundholding and more external administrative structure, protocols and rules to impinge on autonomy. GPs do not take well to being told what to do by fellow GPs or managers but do engage in management more strongly when they can create their own team and work share with them liaising with other professionals by networking. In such a designed structure they are able to devolve financial responsibility but retain financial control and be 'in' management.

## **7.5 Conclusion**

The purpose of this chapter was to present the analysis to address research question five and six: did lead partners continue to engage in management after fundholding; how did lead partners careers fare after fundholding? It seeks to identify if the career choices in management are sustained, the interview method allows GPs to reflect, and thereby the researcher to identify any satisfier, dissatisfier elements and make recommendations for the primary care sector on engagement as a doctor in management in the forthcoming chapter.

Fundholding enabled doctors to decide if they wished to sign up for a management role. The practice went fundholding and the lead partner took the role. The role of doctors in the management of primary care does not have an extensive literature and the most significant transformation of general practice via a NPM led reform has been little documented. This is the only study that progressed case studies of GPs in a management role in primary care in order to identify how doctors engage in management and if that role continues to give insights into a hybrid manager role for doctors. This enables a contrast to the evidence from secondary care and extends the literature on doctors in management in primary care. Table 7.3 compares the evidence in this study to secondary care and completes some of the evidence lacking in Tables 5.3 and 5.4

Contrary to the doctors in secondary care, the doctors in this study who adopted management are satisfied by it. The analysis has shown that there are factors that contribute to the different levels of engagement in management and that even unenthusiastic GPs given the right conditions will engage in management activities which with the right policy will align with more efficient, effective resource allocation in the NHS. It is true to say that not all GPs, given the choice, want to engage in management, and even those that do may not become some level of hybrid manager.

Choice is important for doctors engaging in management. When larger units of accountability reduce choices then doctors may become less involved in the management as work share is manifested; not because of lack of opportunity but the uncongeniality of such arrangements. Doctors become less involved when the notions of professionalism are reduced; essentially the unit domain becomes less of a consideration in the structure. The lack of prescription and training actually worked to the advantage of getting doctors involved in management as it furthered choice. This also suggest that recommending compulsory management training to doctors is counterproductive, some will not want to be managers, some will but may be dissuaded by the prescriptiveness of the training.

The study has shown that doctors are not always defensive towards management. The doctors in the case studies do have a sense of purpose and ambition for management as indicated by the satisfiers *and* dissatisfiers in table 7.2. Further, they do want budgets and accountability as it gives them power to influence and enhance patient care and their role in the NHS. The fight for autonomy does not loom large nor the financial incentives and there is purposeful engagement as indicated by strong and weak hybrid managers.

While accounting itself has not proved significant at practice level; it has created social order and created the opportunity to engage in management. At first, the study concluded that contracting was more important but the visibility that accounting gave was missed on the demise of fundholding. Hence, the allocation of budget at the level of the unit domain of the practice is an important facilitator for engaging doctors in

management. That is not through the purpose of financial incentive but for the change it brings through creating order and visibility is an important consideration.

The evidence from secondary care also suggests that doctors advise others to delegate as much as they can, which brings along the hybridization versus polarisation debate. However, in this study the stronger hybridization is characterised by work share and understanding with the management team of fundholding which work stronger with the outward facing networking activities. That in turn facilitates stronger boundary management to protect the practice and its patients.

## Chapter 8

### Conclusion and Recommendations

#### 8.1 Introduction

This thesis has examined fundholding, an experiment (Broadbent and Laughlin, 1997) in New Public Management (NPM), which exhibited the elements of NPM suggested by Pollitt (1993). It was a voluntary initiative that had implications for accounting (Hood, 1991; 1995) when some General Practitioners (GPs) elected for an increased role in the financial management of primary care. This chapter summarises and develops the work of the previous seven, enhancing the discussion by reflecting on the interplay between accounting practice and management activity, and discusses key contributions. Through an inductive approach and interpretive analysis this study shows how the practice of accounting, creating economic visibility, enabling governance and control by GPs, meant that some doctors in primary care engaged in management. Accounting is shown to be more than a function and technical instrument of NPM (Laughlin, 1991; Lapsley, 1999) revealing interplay between its practice, creating accountability, and encouraging management activity that culminates in its capability to facilitate a hybrid manager role for doctors, previously a profession reluctant to engage in management, (Hunter, 1992; Dopson, 1994; Buchanan *et al.*, 1997). Accounting is found not to be passive and neutral. Accounting is seen to be ‘in motion’ (Hopwood, 1987), it changes the organisation and the role of doctors.

The chapter comprises five sections. The first section summarises multiple reasons for practices going fundholding, the significance of the lead partner and a typology developed to explicate why GPs take a lead role. The second section explains the role of accounting, accountability and its interplay with management activity. The third section covers two key aspects about doctors in management in primary care; firstly the findings of this study relative to the doctors in management literature; then, secondly, the development of the Hybrid Manager Engagement Model (HMEM); The

fourth section identifies some limitations of this study and the opportunities for further research. Finally, the fifth section identifies the principal contributions.

## **8.2 Going Fundholding**

Fundholding applied the four elements (Table 2.3) of NPM (Pollitt, 1993). NPM devolved budgets into the new territory of general practice in order to make that public service more accountable. Resource allocation at practice level and monitoring would utilise the finite NHS resource more efficiently and effectively, and therefore more economically. NPM had significant implications for fundholding (Table 4.6) and therefore Hood's NPM implications of accounting (1991; 1995) had implications for fundholding: cost centre units and identification of costs; private sector accounting norms; more stress on bottom line; fewer procedural constraints; more performance indicators; blurring of pay and activity funds.

This study has shown that there were multiple factors that influenced the design of fundholding (see Figure 2.2) in seeking to contribute to the marketisation of the NHS. The historical context and independent contractor status of GPs within the NHS required GPs, as 'gatekeeper', to be harnessed to help to manage the finite resource of the NHS. Historically GPs had fought and retained independent contractor status but were now given the choice to volunteer for a practice budget. Bound by notions of professionalism (Harrison and Pollitt, 1993) it was necessary to encourage accountability across the practice boundary with top down budget allocation to the practice. To incentivise the intrusion of accountability, fundholding was designed with a financial reward and practices volunteered in waves. Accounting was introduced in the form of a budget for fundholding. New roles within the practice partnership developed – lead partners and fund managers. Accounting was therefore expected to be a fundamental element of fundholding - contributing to how the actors would organise and 'play out' the activity of fundholding.

More recently, this capability of accounting and its role in organizing has been paid attention by recognizing "the mutually constitutive nature of accounting, organizing and economizing" (Miller and Power, 2013, p.557), on reflection, the fundholding initiative is consistent with their meaning for 'economizing'- one of the "processes and practices through which individuals, activities and organisations are constructed

as economic actors and entities, rather than the popular sense of reducing cost or making savings” (p.560). This study examined the *process* of individuals, activities and the fundholding organisation through identifying the key ‘actors’ (lead partner and fund manager). The importance of the lead partner and how the role of accounting was ‘entangled’ (Miller and Power, 2013) in the process was revealed.

The aim was to address the lack of attention to accounting and accountability in primary care given the fundholding initiative, which was particularly surprising given the significant change for the GP as an independent contractor. The study was designed to investigate why the practice chose to go fundholding and how accounting was implicated in the management of fundholding. Multiple reasons were found and have been presented in publications (Cowton and Drake, 1999a, 1999b, 2000). Practices went fundholding and did so across a continuum ranging from protecting the practice to developing the practice (Figure 4.4). Significantly the lead partner emerged as a major factor in going fundholding, even GPs who were not enthusiastic about the scheme itself adopted a lead partner role, and a typology was created: guardians; opportunists; and, reluctant innovators. While the study does not claim that all types of lead partner were identified, it is a theoretical contribution to the reasons why professionals take lead roles in general practice. The study contributes to the fundholding literature from the perspective of not only the organisation, but also from the perspective of the GP. Although this model is derived from one context, this typology presents the beginning of a theoretical framework to help explain why doctors take lead roles on initiatives. These ‘types’ may also be found in other profession where there are opportunities to take a lead role while being mindful of the contextual notions of that profession such as nurses, teachers and lawyers. Such an application in a different context is particularly relevant where increased accountability through the budget mechanism is either enforced, for example head teachers in primary schools, or voluntary, for example the application to become free schools.

The study involved more cases of practices and more private accounts of key actors than any fundholding study published, incorporating more phases and interviewing lead partners after fundholding had ceased. This overcame a concentration of studies on early waves (Glennerster *et al.*, 1992; Glynn *et al.*, 1992) and the views of only

one person within the practice, often the fund manager or practice manager, which had provided a restricted lens with which to view reasons for going fundholding. Those early studies reported ‘fundholders’ to be behaving entrepreneurially (Ennew *et al.*, 1998) which may be due to three factors: early studies concentrated on early waves; it was early waves who were lured by financial incentives that did provide opportunities for entrepreneurial activity; and studies used existing theoretical theories such as entrepreneurship rather than an exploratory approach that this unique NPM experiment deserved. This study avoided the murkiness presented in some studies caused by taking the view of one individual as a practice wide view, by considering accounting as the mechanism that was organizing and enabling fundholding. On reflection, fundholding explored in this way, given the combination of being voluntary and phased, reflected the contextual and messy nature of an organisational change process (Pettigrew, 1992). The ‘messiness’ of the context of fundholding might place this study as one of the few that through its longitudinal nature allows “the change process to reveal itself in any kind of temporal or contextual manner,” (Pettigrew, p.61), as such, it presented the possibility of marrying accounting practice (Hopwood, 1987) and theory about management (Stewart, 1982a; 1982b). The analysis linked the accounting change to what managers do and how they do it. It was seen that in this process of ‘economizing’(Miller and Power, 2013), accounting had a transformative capacity with regard to both the organisation and the individual as accounting practice engaged GPs in management.

The study addressed calls for an examination of accounting implications within the NHS (Lapsley, 1991; 1999; Broadbent, 1992). It seems the significance of accounting in this major change to general practice had been overlooked, possibly as just another NPM initiative and possibly due to a concentration of studies on early waves. Accounting implications were expected to be important because accounting may create change (Hopwood, 1987). Further, when the evaluation of fundholding was biased to the early waves and studies with practice managers (Newton *et al.*, 1993; 1994), rather than the context of fundholding, it ignored the practice as a whole: the nature and history of general practitioner status; accounting in a new space; its voluntary nature; its occurrence in ‘waves’; and, the new roles and potential key players in general practice.

GP practices went fundholding for multiple reasons and accounting contributed to the activity of fundholding, indeed fundholding would not have existed without the delegation of budgets to practice level enabling practices to contract with hospital. With the lack of regulation (Chapter 2) and lack of guidance on how it could be executed and managed within the practice, there were choices to be made by GPs about whether to be a lead partner and further, how they could execute that role. Having established why the lead partner took on the role with a typology, questions were emerging about how the lead partners enacted that role; what did they do and how they did it? With the accounting in place, did they engage with it and its outputs in their lead partner role? However, before the interplay between accounting and the management activity of the lead partner is discussed, it is worth reflecting with some theoretical discussion on the role of accounting and accounting change.

### **8.3 Accounting, Accountability and Management Activity**

This section considers the role of accounting, accountability and how it leads to management activity by the lead partner. This ‘accounting in motion’ “enables the concern of the social...creating organisational practices which can be influential in the construction of the world of the social” (Hopwood, 1987, p.214).

#### **8.3.1 The Role of Accounting: Perspectives of Accounting Change and the ‘Accounting Complex’**

Having addressed why the practice went fundholding and the emergent significance of the lead partner, a further question was ‘how was accounting implicated in the management of fundholding?’ As a researcher coming from an accounting background, in an era of NPM with all its implications for accounting, and from a subjective approach it was sensible to consider fundholding within that framework – that there would be changes and implications for accounting as a result of it being where it was not before. The calculable space was in place and the possibilities of that accounting change (Table 2.1) may have taken one of four perspectives according to Hopwood (1987): organisational improvement; constructing organisational order; construction of social order – visibility, governance and control; and towards accounting in motion – creating organisational practices that are independent of the mechanism and the organisation itself. Most recently, Miller and Power (2013) categorised four key roles of accounting arguing they become entangled to give an

‘accounting complex’ which is messy and constantly changing. It is argued here that accounting in fundholding is an example of an ‘accounting complex’ and that within the ‘accounting complex’, accounting is not a dependent variable nor the independent variable but a productive force of the four roles identified for accounting (Table 8.1): territorialising; mediating; adjudicating; and, subjectivizing.

The accounting change witnessed in this study and its interplay with management activity is a demonstration of the ‘accounting complex’. It is discussed further here in the context of this study and its major findings. *Territorialising* (Miller and Power, 2013) means that accounting is not merely applied to an organisation, that it is active, which is commensurate with the perspectives of Hopwood (1987) and accounting change towards accounting in motion. Accounting had a territorialising role (Table 8.1), linking the marketisation of the NHS to general practice, with an instrument of accounting. The practice became an ‘envelope’ (Miller and Power, 2013) on which calculation could be made. However, the functional and technical aspects of accounting, recording and measuring was found to be in the hands of the fund manager, whether they had an accounting background or not. Accounting *per se* was not important in itself in the fundholding organisation, nor were lead partners trying to understand more about the practice of accounting in fundholding, despite there being a budget in this new territory.

*Mediating* is the process by which the technical instrument of accounting and its processes links up the ‘actors, aspirations and arenas’ as demonstrated in Table 4.8. and the relationship between the lead partner and fund manager. The mediating process is active in the outcome of the factors that influence engagement in management (Figure 6.4). An example of this is the work share with the fund manager and the engagement in public activities such as networking to help boundary management. Further, the *adjudicating* role, of performance measurement for evaluation and accountability is implicit in NPM and its implications as budgets are placed in the territory of the organisation. The accounting for fundholding and the outcomes aligned to it, for example list management and contract performance (see Table 4.8), were made visible to the lead partner, with varying levels of

<b>Roles for Accounting</b>	<b>Characteristics (Miller and Power, 2013)</b>
<b>Territorializing</b>	Recursive construction of the calculable spaces that actors inhabit within organisations. Costs, revenues, risks can be calculated and defined – an envelope can be drawn on which calculations can be made. Accounting is not simply applied to organizational activities – it is involved in constituting those spaces in which it is active. Achieved by linking the ideas of the market with the instruments of accounting.
<b>Mediating</b>	Much of what accounting instruments and ideas do is to link up distinct actors, aspirations and arenas. Goes beyond the technical which are mobilized by broader managerial and societal languages. The mediating and connecting role means that accounting is not always connected to economic outcomes and ideals – economic conception may be at odds with how accounting is actually used. Mediating role is more of a permanent process than a stable outcome
<b>Adjudicating</b>	At a simple level - accounting places a decisive role in evaluating performance of individuals and organisations, also determining failings and failures. Comparison of performance of one organisation against another. As a more general phenomenon - an ‘avalanche’ of mechanisms to achieve accountability and transparency. Creation of territories or entity for accounting and mediation, linkage of actors cannot be dissociated from the allocation of responsibility. Interrelation of accounting, organising and economizing have the most strength at the point of failure or exit from the market game. A factor arising from a cultural imperative to adjudicate at the entity level. This role is not limited in its objects. Accounting can be used by different actors/groups for different purposes.
<b>Subjectivizing practice par excellence</b>	Subjects individuals to control or regulation by another, while entailing the presumption of the individual free to choose. Subjectivizing and responsabilizing. Actors within the organisation are agents who make decisions and choices which are calculable when compared. Significant in shaping the preferences of the actors to whom it provides information. Notion of the calculable self –space/territory of accounting enables certain economic freedom, agents can occupy different roles and react to efforts to account for and evaluate them.

**Table 8.1 The Accounting Complex: An entanglement of four key roles for accounting (Adapted from Miller and Power, 2013)**

‘management’ activity in terms of day to day activity and frequency of interaction with the data but with little concern with the accounting itself. For accounting to be in an adjudicating role it can be used for different purposes, it is not limited in its objects (Table 8.1), for example, contracts may be negotiated on price to make savings but underutilised contracted capacity can be identified to manage waiting lists. This

demonstrates the mediating role of accounting (Table 8.1), linking up the distinct actors of fund manager, lead partner and entities, which enable lead partners to take on levels of management activity – accounting in motion, transforming the GP to a hybrid manager in some cases, making choices – and demonstrating the subjectivization (Table 8.1). Thus, the factors that influence the design of fundholding (Figure 2.2.), the reasons for going fundholding and the accounting implications for the key players, what they did and how they did it led to the adaptation of a model designed to help understand managerial jobs (Stewart, 1982a; 1982b). The model was used to analyse demands, constraints and choices (see Table 6.3 and 6.4) and has enabled insights into this ‘accounting complex’.

The lead partner makes choices in his personal domain once he has chosen the lead partner role. This had implications from the perspective of accounting change and the level of engagement in management as a guardian, opportunist or reluctant innovator. This is consistent with Miller and Power’s notion of the calculable self where the territory of accounting enables certain economic freedoms with agents occupying different roles and reacting differently within their working practices.

### **8.3.2 Accounting Change - Accounting as a Productive Force**

This ‘accounting complex’ generates accounting into a productive force and each case in the study is dependent on the context of its application. Accounting in this context was based on aspirations for its ability to help with managing finite resources in the NHS, hence organisational improvement (Table 2.1). Further, accounting had been documented in the construction of organisational order as part of NPM (Glynn *et al.*, 1992; Humphrey *et al.*, 1993; Humphrey, 1994; Laughlin *et al.*, 1992; 1994; Llewellyn, 1998) with tensions, resistance and dysfunction reported. In this study, accounting was found not to be significant in those features of accounting change:

- There was little evidence of demonisation (Lapsley, 1999)
- No explicit conflict with the values and norms of medical services (Lapsley, 1991) by those choosing a lead partner role - in fact it seemed to harness them by engaging doctors in management activity

Perhaps fundholding placed accounting in a central role after all to contribute to a philosophy for efficiency and effectiveness (Broadbent, 1992) as some GPs participated in management activity. Something was happening because of the accounting change and the ‘economization’ as the economic actors and entities made choices about the processes and practices they wished to engage in, and accounting was certainly no longer simply passive and bureaucratic (Ezzamel and Willmot, 1993). Accounting within the organisation was enabling a management role to be enacted and the potential for a hybrid manager role for GPs. Accounting is found in a pivotal role within what Miller and Power (2013) recognise as a ‘messy world of everyday life’ and as such its practice cannot be divorced from its interplay with management activity.

Three of these roles of accounting; territorialising, mediating and adjudicating emerge from *this* research, how the fund manager and lead partner mediate and their roles take different forms – the ‘accounting complex’ then engages the GP in a management role. The final element of the ‘accounting complex’ has a strong emergent role in this study – “Accounting is a subjective practice par excellence...calculative technologies at the heart of that most private of domains – the individual and her choices or decisions,” (Miller and Power, 2013, p586). In this case accounting was placed in a new domain – a very private domain of an independent contractor - and gave visibility across the practice boundary as part of the marketisation of the NHS. It is clear that the implications of this accounting complex transcend the level of the organisation as some GPs took a lead partner role and some began to engage in management. The implications that accounting had for engaging GPs in management is well summarised by a quote from the Miller and Power (2013) paper – “If management without accounting has become unthinkable, accounting also makes management thinkable and actionable in specific ways,” (p.561) which leads into the next section, as a pre-cursor to discussing the Hybrid Manager Engagement Model (HMEM).

### **8.3.3 From Accounting to Accountability, from Accounting Change to Management Activity**

The significant role adopted by the lead partner, now clearly identified, also raised the question of *how* they engaged in the management of fundholding. It was found,

firstly, that all other partners in the practice delegated fundholding management to whoever was named as lead partner. Secondly, there were different types of lead partner dependent on the practice reason for going fundholding and the enthusiasm, or not, of the lead partner. It was reported in the literature that many gatekeepers did not engage in day to day activities of accounting or interact with data at a level that would influence the allocation of resources. Such polarisation (Jacobs, 2005; Ostergeren, 2009) of the management function was usually attributed to the delegation of the accountability mechanism to non-medical personnel. Thus while other studies recognised there was some role for accounting in the management of resources, it was not those who were most knowledgeable and targeted that were in engaging; they were, in fact, reported as delegating. Indeed, that was the case found in secondary care and also found here to some extent in primary care. This is an example of the messiness of the ‘accounting complex’. On the face of it, fund managers were absorbing the administrative and accounting function itself and because their role was created they were being delegated to. However, by examining the role of accounting and the ensuing question of what lead partners did and how they did it, it avoids such a simplistic view because the ‘accounting complex’ is exposed and it becomes apparent that accounting was important in facilitating management activity for some of the GPs. This is an example of the third body of work sought by Miller and Power (2013) as this study has an emergent focus on “processes by which accounting representations and metrics are simultaneously powerful interventions which shape, people, practices and organisation,” (p.558). Lead partners did not get involved in the process of accountability (day to day activities and use of data) but used the broad visibility that the introduction of an accounting function provided. Some lead partners took a management role which was enabled by the entangled roles of accounting in presenting a ‘sum’ of the ‘accounting complex’. For example, some were engaging in strategic activity, contract and performance management, and there were different degrees of work sharing and networking. What was intriguing and a valuable contribution to developing a theory of engagement was how they did what they did when the accounting schema produced accountability – it set in motion different ways for GPs to act out their management role and forge activity within primary career.

## **8.4 Doctors in Management in Primary Care**

This section covers two key aspects; firstly the findings of this study in primary care relative to the doctors in management literature; secondly, the development of the Hybrid Manager Engagement Model (HMEM). The adaptation of the Stewart (1982a; 1982b) model enabled an analysis of how the management role was enacted. A model was constructed of the factors, and their direction, to characterise a level of engagement in management by doctors in primary care (Figure 6.5) – the HMEM. This produced new key findings about doctors in the management of primary care to add to the existing literature (Table 5.4) which is predominantly in secondary care.

### **8.4.1 The Case in Primary Care**

The literature on doctors in management reported a problem with getting doctors engaged in management, firstly in secondary care, but also in primary care. Doctors in secondary care were reported to be reluctant to engage in management and those that did, did so with half-hearted motivations such as those reported by Fitzgerald (1994): part-time; boredom; political; seeking any challenge. The literature was criticised for being focussed on definition, of what ought to be done by doctors in management, rather than what is and what they did (Dopson, 1996). Buchanan *et al.* (1997) moved beyond that deficit model, of what was lacking that caused doctors not to engage in management in secondary care to examine what hospital doctors actually did and experienced when involved in management. This study addressed the failure to examine what GPs did (primary care) and experienced when involved in management using the time frame of fundholding. Those findings from secondary care were used as a framework to consider and evaluate the gaps in the more slowly emergent primary care literature (Figure 5.3).

This study has contributed to understanding of the factors that influence doctors in primary care to engage in management activity and found it to happen more when linked closely to primary profession decisions and in alignment with the notions of professionalism when in practice. Moreover, it is effective when accounting practice is within the domain of the GP practice and has proximity to GP decision making at a professional level, even if it is not explicit in those decisions. After the demise of fundholding the doctors in management literature opened up an ‘engagement’ debate in secondary care but not in the domain of primary care, which had reverted to a

traditional structure when GPs relinquished budgets, hence financial accountability, to PCGs and later PCTs. Thus, the secondary analysis of the interviews from phase one enabled consideration of the later developed literature and a comparison between secondary and primary care to a depth not possible when fundholding was alive; fundholding has a legacy in providing a historical snapshot of when GPs became engaged in the management of primary care which does have implications for existing and future reforms and policies.

Therefore in the first instance the study adds to our understanding of doctors in management by overcoming the deficit model of what ought to be, but, importantly, the study adds to the literature on doctors in management by examining accounting practice in the context of accounting change, and on reflection, the ‘accounting complex’ as a productive force. It moves the doctors in management literature forward from the context of winners and losers in NPM, and doctors in power battles (Hunter, 1994; Morris and Farrell, 2003) to show the power of accounting itself (Roberts and Scapens, 1985) which gave GPs the power to do something different, through accountability. It shows accounting change as transformative, ‘in motion’ (Hopwood, 1987), rather than an example of players creating power over accounting when there are implied dysfunctional consequences – the latter more associated with Hopwood’s (1987) paradigms for organisational improvement and organisational order, which ignores ‘management discretion and choice’ (see Table 2.1).

There is a distinct body of research on doctors in management that highlight reluctance and delegation. However, this study has found that doctors engage in different ways and at different levels which can be interpreted as different level of hybridisation. Thus, if future policy insists on a management role for doctors in primary care these factors can be taken into consideration in designing the commissioning models. Research on other models of engagement can be compared to the findings in this study. If doctors are given financial accountability within the practice domain they have been shown to engage in activities with other players which leads them into management within and beyond the practice boundary.

The study has found that getting involved in management is personal to the doctors in primary care – a clear case of the subjectivization role for accounting. The reasons

they took on the role showed varying degrees of enthusiasm and different types of doctors in management: guardian; reluctant innovator and opportunist. Llewellyn (2001) concluded that doctors may risk losing clinical visibility and respect and will therefore present the management tasks as supplementary. The doctors in management literature reports that management roles are often not sustained on the 'rare' occasion they are taken. The demise of fundholding disengaged doctors from a lead partner role in fundholding but raised the question of whether other manager roles were taken. It was found that GPs in this study did seek management roles after fundholding, some were successful in obtaining them, and others were not. Further, by being able to reflect on their fundholding experience, conclusions could be made about the elements that contributed to satisfaction and dissatisfaction with a management role, hence what might encourage doctors to engage in management.

#### **8.4.2. The Hybrid Manager Engagement Model**

The study has identified that there are different levels of hybrid manager's activity (Table 6.62) that are facilitated by different factors (Figure 6.6). The concept of a hybrid manager had been criticised for being a mere description of a role (Dopson, 1996). There was a lack of evidence in the literature of how that role was executed by doctors in management which has been addressed and analysed in this study. Although Jacobs (2005) did extend the conceptualisation of hybrid manager, by introducing potential for hybridisation versus polarisation in secondary care, he did not develop the types of hybrid manager, although it did show non-medical managers take the management 'burden'. Accounting was implicated in that process of polarisation in a very simple way, through evidence of financial argumentation (Jacobs, 2005). There was no attempt to consider how accounting might be implicated at both organisation level and actor level in hybridisation as part of an 'economizing' role. On reflection, the modelling of the factors that influence engagement in management and management activity is largely facilitated by the productive force of the 'accounting complex' and the differing role for accounting. Although accounting may not be a *force majeure* in getting doctors involved in management, it is certainly implicated, and found to be favoured by those who had the opportunity to be fundholders in a lead GP role.

One of the strengths of this study is that it did not rely on self-reports of individual doctors about their involvement in management. The analysis (Table 6.3 and 6.4) avoided direct questioning. As there are widespread negative beliefs amongst clinicians about the nature of managers and management, it is worth pondering whether it might be difficult for doctors to say anything other than that they do not really want to be a manager and, if they are, they would prefer to return to full-time medical work. In a professional setting it can be hard to admit to enjoying being in a position which makes one, in some sense, the ‘boss’ of one’s peers; the notion of the ‘reluctant ruler’ is far more acceptable. At the very least it suggests the importance of posing questions very carefully, including seeking to gain a properly contextualised appreciation of expressed attitudes. Therefore, the framework for analysis used in this study is useful in this context and may be applied in other institutional contexts to understand accounting, the complexity of the roles for accounting and the interplay between it and management activity.

Direct questions can lead to interviewees responding with what he/she think they should respond with hence, by analysing accountability (through the presence of accounting activity – Table 4.8) and the choices of lead partners, the potential for accounting change (Hopwood, 1987) and the productive force of accounting (Miller and Power, 2013) was revealed. This has produced the sum of activity in the job with the adaption of the Stewart model (1982a, 1982b) that revealed more about the hybrid manager in this context at least. Further, analysis of the case studies have given indicators of activity that presents a case for different strengths of hybrid manager, albeit only ‘strong’ or ‘weak’ at this stage of development of a Hybrid Manager Engagement Model (HMEM). Further, this approach to analysis of accounting change in a specific context has overcome the narrow functionalist approach towards the role of accounting which has been criticised by Lapsley and Pettigrew (1994) who suggested that the change process is better understood in context. Further, the historical and temporal nature of fundholding in this study is shown to be comparable to Pettigrew’s (1992) argument for contextualist research having value in marrying theory and practice, to help understanding and thus giving “history and social processes the chance to reveal their untidiness” (p.62). For some GPs the choice to go fundholding has engaged them in the process of change, brought about by NPM. The

implication of accounting is that it has engaged some GPs in a separate activity to their primary role, that is, management, becoming hybrid managers as accounting practice and management activities mingle. Moreover, this study in context has enabled the development of a theoretical model which may be applied in other contexts where accounting is placed, to be used and adapted in the context of the situation to which it is to be applied to understand the interplay between accounting and management activity.

The hybrid manager was a mere concept with some elaboration of hybridisation/polarisation. Empirical research reported hybrid managers as reluctant, volunteering for management for negative reasons (Cavenagh, 2003; Dopson, 1996; Dopson and Fitzgerald, 2006). This study reveals a typology for those taking on lead roles, recognising different levels of enthusiasm, and develops a HMEM which is supported by interviewees reflecting on their time in management roles. Therefore the study also goes a step further by addressing career, post management role, which is important as hybrid roles were often left to return to a clinical specialism (Buchanan *et al.*, 1997). The departure from management was taken as support for a general view that doctors were negative about management and reluctant managers without asking them to reflect on their time in management.

Those who had strong engagement in the management in fundholding, as evidenced by what doctors did in their management role (Figure 6.4), did continue engaging in matters that indicated activity in 'management' e.g. committee involvement, engagement in networking for the new forms of accountability under PCGs and PCTs, lead roles in the practice away from doctoring. However, engagement may have been weakened by the lack of opportunity to participate, but there could still be choices about engaging in a management role. The PCG and PCT structures meant GPs could still participate but there were unfavourable conditions according to the HMEM: they did not wish to work share with fellow GPs; a lack of financial data with proximity to practice decision; lack of financial accountability and overall lack of focus on the practice/unit domain. Even weak hybrid managers continued to take lead roles in the practice and surprisingly seemed to have acquired a taste for management and actively sought committee representation but were disappointed when not successful. Even those who engaged the least in management activities as fundholders were still

involved in seeking or acting in management type positions but, like weaker managers they were put off the process either because of apparent politicisation or unhappiness with what the management role looked like. Ultimately, the second phase of data collection enabled identification of the satisfiers and dissatisfiers of being involved in management, pursuing the phenomenon of management, in order to complete the missing analysis for primary care relative to secondary care (Table 5.3). Further, it enabled development of the model with which to recommend the activity that might engage GPs in management.

There are two significant contributions of the study that increase our understanding of accounting practice and its interplay with management activity:

- Accounting is seen in motion, transforming the organisation, creating a new role for the GP independent of accounting itself as the GP becomes a hybrid manager contributing to the management of the NHS.
- The ‘accounting complex’ is a driving force in the organisation going beyond organisational improvement and order. To understand it one must look at context including the historical background of the profession, and particularly the actors, what they do and how they do it in order to gain a richer and more realistic understanding of management particularly where there is a hybrid manager role. It is not sufficient to ask the actors what they do.

## **8.5 Limitations of the Study and Recommendations for Further Study**

This section summarises the limitations of the study and recommendations for future research.

### **8.5.1 Limitations**

There are a number of limitations as summarised below.

1. Firstly, there are only twelve case studies in phase one and six of those are continued in phase two. The results are inferred from the findings and do not contest that all types of lead partners were found, nor that the levels of engagement of GPs in management are conclusive and that there are not other levels of engagement. However, most of the studies of GPs (Table 5.2) are of single practices and of less than 12 interviews therefore the twelve case studies

are useful in the breadth of waves and do present variety. Although only half were available for the second phase, no other study has examined lead partners post –fundholding and there was a balance, more good fortune than planned, across the different categories of hybridisation presented in the HMEM.

2. Geographically the practices were from the same county in England and there may have been regional variations that would have impacted on the results. Further, practice demographics may also be a relevant variable but was outside the scope of this study. Indeed, pre-occupation with demographics has been argued to hinder some of the more qualitative aspects that could have contributed to policies for the NHS.
3. The thesis does not examine GPs in non-fundholding practices or GPs in fundholding practices who are not lead partners (although they are an element of the practice perspectives in going fundholding) but does provide evidence for doctors in management in primary care. It does show that some doctors will participate in management, given the choice, and even those who are unenthusiastic and reluctant about management will participate if the scheme is designed such that they can develop or protect the practice and patients. Further, those who have participated have enabled levels of engagement to be investigated to inform how others might be encouraged. The evidence suggests that schemes to involve doctors in management must look at context and avoid a universal approach for the profession which is often based on assumptions about negativity towards management. This would inform the design of schemes to assist in achieving the objectives such as the broad application of NPM or other initiatives.

### **8.5.2 Recommendations for Further Research**

Further research should be conducted in three main contexts. Firstly, in applying and developing the typology and model to refine it and identify further factors that influence engagement in management alongside a primary career. The perspective of the model could be extended by identify perceptions about successful contributions to management. Secondly, by researching how other primary career holders engage in

management roles in other professions and organisational settings similar to Pilbeam and Jamieson (2010) in higher education. Thirdly, by expanding the study of doctors in management.

### **Apply and Develop the Model of Engagement in Management**

The adapted model from Stewart (1982a; 1982b) and interrogation questions (Table 6.5) can be used to examine how welfare professionals engage in management, ideally in the first instance a suitable institutional setting would be in the latest practice based commissioning and hospitals settings. However, the model and method could also be applied to other welfare institutions as they may become subject to accountability, perhaps as new public governance is rolled out, for example, free schools and academies. In addition to welfare organisation the HMEM (Figure 6.5) could be adapted and contextualised by researchers in other partnership settings for professionals; for example, the role of management partners in legal and accountancy practices. The model applied to interviews would be enhanced by participant observations in institutional settings.

At the next level the model may be further developed to introduce the factors that are deemed success factors for engagement in management. The researcher would strongly support the notion that not all professionals should be forced to engage in management activities, if engagement is to be effective, but that certain factors may contribute to stronger and better engagement .

### **Professionals Engaging in Management**

There are an increasing number of governance structures, management structures and examples of consultancy associated with the semi-public sectors, particularly health and education. It would be beneficial to extend and develop studies of why professionals choose a hybrid manager (or even a non-executive) role and how they execute it in order to meet organisational objectives to highlight demands and constraints. Such cases would help build up knowledge and good practice for those entering a hybrid role. Such studies, like this one, may provide insights into how funding mechanisms might be designed to draw the professional into a hybrid manager role.

## **Practical Implications – Studies in the NHS**

Fundholding provided the first window of engagement in management for GPs. Commissioning structures are pertinent with the return of the Conservative government (although in coalition) and the plans to return some power and funding to primary care. Studies of fundholding frequently suffered from the assumption that the practice view was the consensus view about GPs' engagement in fundholding, hence GPs engagement in management. This study shows the importance of the individual GPs. It is argued that the legacy of fundholding is broader, through the contributions noted here, and longer, in the accounts of those living and learning from the experience.

The study shows the importance of the individual and the context of role and activities in achieving organisational objectives when there are choices about getting involved in initiatives such as those backed by NPM or new public governance. Therefore it will be important to examine doctors in management in the NHS and the developing private sector, such as the latest commissioning models. The latter would be fascinating given the combined practice structures and the possible models for financial responsibility. Indeed, Miller *et al.* (2012) in reviewing clinical engagement in primary care-led commissioning cite the published work from this thesis (Cowton and Drake, 1999a and 1999b) as support for the need to address clinical leadership carefully, and it is argued here that one variable that need careful consideration is that of financial responsibility, specifically how the form of accounting will interplay with management activity.

## **8.6 A Summary of Principal Contributions**

There are four categories of contribution: a broad contribution to the literature on NPM by investigating its impact on an organisation (Hughes, 2010) from the perspective of accounting change in the semi-public sector; a contribution to the management of primary healthcare; at the individual level in a professional capacity as it reveals how some GPs involve themselves in management; at a theoretical level, in two ways, by developing a typology with which those taking on lead roles can be classified, and, by introducing the HMEM with which to identify factors that influence individuals to engage in management roles, in this context, GPs.

The principal contributions, in addition to a more general understanding of the role of accounting and doctors in management, are summarized below.

1. This study has examined a prodigious and unusual child of NPM. It has followed the fundholding 'experiment' in organisational improvement beyond its end by examining the impact on some of those who lived the experience. Whereas accounting and accountability has been explored in the literature, through institutions touched by NPM, it was about what it could do, rather than what it actually did. It has paid attention to notions of accountability alongside notions of professionalism and it is argued that by doing so accounting must be seen as more productive than a mere technical instrument for organisational improvement. Future commentators on both NPM and the capabilities of the accounting as a technique, need to consider the different perspectives of accounting change, the assimilation of the roles for accounting that contribute to the 'accounting complex', and how actors link with the responsibility because accounting practice and management activity are inter-linked.
2. It contributes in the simplest sense as a study of an application of NPM that was unique because it was voluntary rather than compulsory as in other institutions. Fundholding is identified as case of the success of disaggregation of budgets to a smaller unit releasing the potential of an accounting technique to engage some GPs in management of the larger NHS resource. However, the study does not claim to state whether fundholding as a constituent of larger NHS policy was a success, merely that where doctors were largely reported as reluctant, often adverse, to engage in management, fundholding succeeded in engaging them. Indeed, it was missed by even by unenthusiastic GPs on its demise, even when alternatives in larger units of accountability were available (PCGs and PCTs).
3. The study contributes to the primary health care management literature as an example of a GP commissioning model, which is a subject revisited in the

NHS, and pertinent today. When policy is implemented there is often reported initial reaction and research but on rare occasions, such as in this study, the impact may transgress the time of the reform. It is argued that the second phase of data collection is important to complete the picture of the phenomenon of fundholding which engaged some GPs in management, enabling participants to reflect. As a contribution to primary healthcare management, fundholding was the pre-cursor for numerous changes in general practice. A number of interviewees commented both on and off tape during the second phase that this study had important implications for the ‘family doctor’. It is argued that fundholding documents the beginning of the demise of the ‘family doctor’ and is an important event in the history of general practice. It extends the understanding of fundholding because it:

- Covers a broader range of waves
  - Opened up the perspective of the fund manager, who was or was not, the practice manager incumbent prior to fundholding
  - Investigates multiple practice reasons for going fundholding and provides a deeper understanding of the issues
  - It is a panel study as part of the longitudinal approach with the same subjects interviewed twice (GPs)
4. It links accounting practice to management activity as the ‘accounting complex’ is a productive force where the roles for accounting: territorialising; mediating; adjudicating and subjectivizing work together, and in this case facilitate a hybrid manager role for some GPs. It shows how accounting, though not important on its own, was implicated in the creation of social order and shown to be ‘in motion’ and as such contributed to the engagement of GPs in management. Accounting, organizing and ‘economizing’ has engaged GPs in management. It presents an example of accounting in motion creating an example of the ‘accounting complex’ of fundholding. Therefore, as an experiment in NPM, it provides a contrast to the emphasis on the dysfunctional consequences (Hopwood, 1987; Laughlin *et al.*, 1994; and

Humphrey *et al.*, 1994) and demonisation of accounting (Lapsley, 1999) associated with accounting change.

5. The study contributions to the doctors in management literature. As some GPs took a management journey, the trajectory of the thesis changed from an emphasis on the role of accounting *per se* towards its contribution to develop a HMEM. By gaining an understanding of the managerial job and behaviours, what they did and how they did it, within an ‘accounting complex’ (Miller and Power, 2013) in this contextualised research (Pettigrew, 1992), a rich vein was opened. This has added to the literature on doctor in management, particularly in primary care, redressing the balance of a literature heavily focussed on secondary care. The study adds a new dimension to the doctors in management literature by revealing how the personal domain progressed. This is a valuable contribution because it has implications for other models of doctors commissioning care particularly the multiple practice commissioning models. The notions of professionalism may be less satisfied when GPs work share with fellow GPs at practice level and that may be exacerbated when that sharing is with GPs outside the individual practice domain. It is argued that some GPs would be less engaged in schemes that do not have financial accountability and control for the practice domain and which has less relevance for the individual practice and patients. The doctors did miss the financial control available through the design of fundholding. Therefore delegated budgets are a factor that will influence GPs into management roles but the level of engagement will depend on the design of the scheme and the choices made by individuals. It is argued that a professional lead (GP) should be sought out, to work with the administrative teams to encourage internal expertise and promote networking to achieve efficient resources management at the micro-level for the macro aims. There is a need for doctors as managers and this can be achieved through careful design of the accounting mechanism.
6. The first theoretical contribution is a development of a typology for taking lead roles which later contributes to the development of the HMEM. The

typology presents an interface between the organisational motivations for taking on a particular initiative and the role of the lead, who ‘chooses’ that role. It is based on the ‘lived experience’ (Silverman, 2004) and its analysis and exposition (Figure 4.4) may be applied in different contexts and the typology expanded accordingly.

7. Finally, the second theoretical contribution arises from finding that doctors in primary care engage in management in different ways and to differing degrees. Those factors that contribute to engagement in management have been conceptualised and modelled for the first time to present levels of engagement (Figure 6.4) in the HMEM. The facilitating factor in the HMEM model is the presence of accounting, in this instance of budget allocation to the unit domain of general practice, therefore the model is significant in developing an understanding between accounting practice and management activity. It takes the role of hybrid manager beyond a concept to a working model that can be applied, and further developed in different contexts.

## **APPENDIX 1**

### **Phase One Interview Questions**

#### **Lead Partner**

1. Whose idea was it that the practice should go fundholding? When was that?
2. What were the views of the partners about going fundholding?
3. How did you decide who should be the lead partner?
4. What do you see your role as?
5. How did the practice recruit the fund manager?
6. How was the practice developing over time before fundholding?
7. How has the practice developed over time since fundholding?
8. How did you introduce the initiative into the management of the practice?
9. Did practice members have any special training or study? How do you think that went?
10. Did you note any advantages or disadvantages of the way the initiative was introduced?
11. Is there something you know now that you wish that someone had told you?
12. What are the critical aspects of successful fund management?
13. What do you do with the information received from the fund manager? And how do you receive that information?
14. Is there any information that you do not receive that you would like to receive?
15. Why did you choose the computer package?
16. What aspect of fund management do you spend most of your time on?
17. What are your priorities for the year ahead?
18. What is the future for fundholding in this practice?
19. How would you like to see fundholding develop? And how would this change things for you?

## **Fund Manager**

1. Whose idea was it that the practice should go fundholding? When was that? Why was it that wave?
2. What were the views of the partners about going fundholding?
3. What employment background do you have?
4. How did you decide who should be the lead partner?
5. What do you see your role as?
6. How did the practice recruit the fund manager?
7. How was the practice developing over time before fundholding?
8. How has the practice developed over time since fundholding?
9. How did you introduce the initiative into the management of the practice?
10. Did practice members have any special training or study? How do you think that went?
11. Did you note any advantages or disadvantages of the way the initiative was introduced? How has it progressed over the years?
12. Is there something you know now that you wish that someone had told you?
13. What financial information do you pass on to the lead partner on a regular basis? How do you pass that information on?
14. What does the lead partner do with the information you give him?
15. Why did you choose the computer package? What do you think of that package?
16. Who has advised you during fundholding?
17. What are the critical aspects for fund management?
18. What aspect of fund management do you spend most of your time on?
19. What are your priorities for the year ahead?
20. What is the future for fundholding in this practice?
21. How would you like to see fundholding develop? And how would this change things for you?

## APPENDIX TWO

### Phase Two Interview Questions

Thank you for agreeing to this interview. Casting your mind back I interviewed you in... and asked about fundholding and why the practice chose to go fundholding, how you became the lead partner. It was very helpful and I published a number of journal article so thank you very much. The purpose of this interview is to consider changes since then in the management of health care especially changes for you.

1. Please tell me about your experience of being part of a primary care group.
  - How were you personally involved in PCGs?
  - What role did other partners take at that time?
  - Who got on committees and why?
  - What did the practice get from being in a PCG?
  - And what did you get from being in a PCG?
  - What worked well in PCGs?
  - What didn't work well in PCTs?
  - What were the respective roles and contributions of GPs and professional managers in the work of PCGS?
  
2. Please tell me about your experience of being a part of a primary care trust?
  - How were you personally involved in PCTS?
  - What role did other partners take at that time?
  - Who got on committees and why?
  - What did the practice get from being in a PCT?
  - And what did you get from being in a PCT?
  - What worked well in PCTs?
  - What didn't work well in PCTs?
  - What were the respective roles and contributions of GPs and professional managers in the work of PCTS?
  
3. How have you been involved in the management of secondary care?
  
4. How would you summarise your career has developed:
  - technically
  - managerially
  - creatively
  - security and stability
  - being autonomous and independent
  
5. Thinking back how would you summarise the changes to the practice since fundholding? What were the highs for the practice and the lows?
  
6. What were the highs for the you and the lows since fundholding?
  
7. Is there anything else that we have discussed today that you would like to elaborate on??

### APPENDIX 3

Author ( Date)	Title	Country and Organisation Setting	Method	Sample	Key Theme and Key Findings
Brazell (1987)	Doctors as managers	UK, Hospital	Interview	15 doctors including 11 hospital and 1 GP. Questionnaire follow up (27/101 replies)	Doctors viewed that they have a management role to play, are confused about management roles and a reluctance to accept management. Doctors thought that they should learn about management but that if they did it should have a high reality for their work.
Mark (1991)	Where are the medical managers?	UK NHS Generally	Discussion Paper	N/A	Considers the attempts to develop medical managers and need for detailed research study. Suggests that organisational considerations are an incorrect approach to such development and that individual career paths within an NHS learning organisation is the way forward. Observed a decrease since Griffiths in the number of doctors in management posts and lack of role models for doctors considering a shift into management. Concluded that individual career paths are key to organisational effectiveness. Concluded that individual development through education would be key.
Hunter (1992)	Doctors as Managers: Poachers turned gamekeepers	UK	Discussion Paper	N/A	Reviews debate about doctors and managers and value bases, considering issues at meso and micro level.

Newman and Cowling (1993)	Management Education of Clinical Directors: An Evaluation	UK Hospital	Interviews (structured and semi-structured) ; Pre-and post course self-efficacy questionnaires	2,000 interviews	National Evaluation of government sponsored programme to send consultants to Business School management programmes in 1992-93. Course participants were found to feel more confident in current, and for, prospective management roles. Relative to doctors in management concluded that: management development should begin in medical school; management development for consultants should not be an isolated activity; management development was required after managerial post appointment.
Newton <i>et al.</i> (1993)	Managing the Fundholding Practice: Who does what?	UK GPs	Semi-structured interviews with clinicians and practice managers. Two phase.	10 first wave practices. Random selection	Recognised that being able to be fundholding depended on administrative and IT capability and no one could “predict how fundholding would be managed in practice”. The study looked at practice managers and clinicians. First phase studied process of becoming fundholders (practice manager and lead partner but not fund manager) and second on changes in practice management and organisation. Identified that structures did not change and decision making was by the ‘clinical partners’. Key feature was practice ability to develop as small business indicated by business plans and management systems supported by IT. Concluded it worked well despite continuation of traditional approaches.
Newton and Robinson (1994)	Fundholding in Northern region: Practice Managers Views	UK Practice Managers	Questionnaire	22 Practices	First, second and third wave practice managers involvement and views of the scheme and their developing roles. Concluded a support (rather than lead) role in fundholding.

Cowling and Newman (1994)	Turning Doctors into Managers: an evaluation of a Major NHS Initiative to Improve the Managerial Capabilities of Medical Consultants	UK Hospital	Interviews (structured and semi-structured) ; Pre-and post course self-efficacy questionnaires	2,000 interviews	Report on experience of Newman and Cowling (1993).
Dopson (1994)	Management: the one disease consultants did not think existed	UK Hospital	Semi-structured interview (two phases)	16 Consultants	Progress in getting doctors involved in management in a secondary care setting.
Mark (1994)	Medical Management: Reflecting on Some Ripples in the Pond	N/A	Reflective	2 research projects	Reflects on impact of doctors having being in a management role. Risk of not capturing the impact of medical management. Concludes there is a need for management training even if it only provides doctors with evidence that they do not want to be involved in management.
Fitzgerald (1994)	Moving clinicians into management: a professional challenge or threat?	UK Hospital	Interviews	31 clinicians	Examines issue of drawing clinicians into management and widens debate about medical profession dominance through the examination of stages of training. Argues need to analyse in the context that they work in relative to role and activity. What motivated into management role and how they perceive their position is part of the study. Identifies three dimensions why they are drawn into management: from making assessment and judgements about the changes in health care; attraction of part-time

					rather than giving up primary profession; challenge of management i.e. stimulation and interest. Opportunity to be involved in key decisions was an attraction.
Allen (1995)	Doctors in Management or the revenge of the conquered: The role of management development for doctors	UK Profession	Historical review	N/A	Considers the factors that have influenced the evolution of doctors in the management of the NHS since Bevan. Concludes that management training is worthwhile and suggest that doctors' views on management of the NHS would change after 'some involvement' in management.
Dopson (1996)	Doctors in management: A challenge to established debates	UK Hospital	Semi-structured interview	32	Consultants struggled to decide if management was benefiting the patients; were feeling guilty about spending money on management development especially in the absence of a clear career path in management; most of the consultants were reluctant managers. Recognise problem of modelling clinical directors on an average general management role.
Gatrell and White (1996)	Doctors and Management – the Development Dilemma	UK Wide groups including Hospital, GPs, Chief Executives, Different Trainees	National Survey, Questionnaire, and In depth interviews	>1000, 1420, 230	Study of what managerial knowledge and skills required by clinicians and to develop and define the development needed by exploring management activities of different grades of doctor. Conclusion included the need to consider different learning styles of different doctors and a need for managers to improve their image within the medical profession.

Greenfield and Nayak (1996)	A management role for the General Practitioner	GPs	Study 1 (pre new GP contract): Postal questionnaire (168/307) responses Study 2 (post new GP contract):		Hostility of GPs to having management role thrust upon them. Different practices responding differently to how changes were put on them in terms of organisation of management and administration. Any management training was too general and not specific.
Llewellyn and Grant (1996)	The impact of fundholding on primary health care: accounts from Scottish GPs	UK General Practice	Interviews with 5 lead GPs	6 Case Studies	Focus on prescribing, consultations, referrals, GPs as resource managers. The latter related to making more cost conscious. Interpreted GPs to have an enhanced management role, some enthusiastic and became 'entrepreneurs of healing', delegating administrative tasks. Calls for more strategic approach to management development in order to identify those doctors who have an aptitude and interest for it and to help design appropriate programmes.
Walker and Morgan (1996)	Involving Doctors in Management: A Survey of the management development career needs of Selected Doctors in NHS Wales	UK Hospital	Survey	209 senior registrars and 269 consultants	Survey to identify development needs based on finding it to be unstructured and poorly co-ordinated, yet doctors keen to be involved in management. Identified desired categories of management education from hospital doctors.

Buchanan <i>et al.</i> (1997),	Doctor in the process: the engagement of clinical directors in hospital management	UK Hospital	In-depth interviews. Content analysis.	6 clinical directors and 19 other hospital management team members	Medical involvement in the hospital management process. Explores and moves beyond the deficit model of management competencies and on engagement of doctors in the management process.
Ong (1998)	Evolving Perceptions of Clinical Management in Acute Hospitals in England	UK Hospitals	Secondary data. Interviews. Two phases.	3 directorates 40 Interviews: Directors, executive team, GPs	Explore issues of how clinicians construe their roles. How the clinical director role is perceived and the link to organizational change. Confirms debate is often focussed on professions and power.
Warwicker (1998)	Managerialism and the British <i>GP</i> : the <i>GP</i> as manager and as managed.	UK General Practice			Analysis of the managerialisation of GPs.
Maddox (1999)	General Practice Fundholding in the British National Health Service Reform 1991-1997: GP accounts of the Dynamics of Change	UK General Practice	Panel Interviews	6 GPs, first wave only	Insights into complex dynamics of the reforms and emerging concerns. Increasing concerns with general issues of policy as progressed and they became less 'hands on'. Led to a later, cautious and negative start of future involvement in PCGs in leadership roles.
Fitzgerald and Ferlie (2000)	Professionals: Back to the Future	UK Hospitals	Longitudinal (1990-94) Observation	Not clear	Impact of quasi-market on professionals particularly power and autonomy. Identifies the product of the quasi-market is a new category of professional managers who actively

			Interviews, questionnaires, archival		manage ‘colleagues’ performance. Notion of hybrid manager. Focus on the negative i.e. loss of power and autonomy.
Kitchener (2000)	The ‘Bureaucratization’ of Professional Roles: The Case of the Clinical Directors in UK Hospitals	UK Hospitals	Longitudinal (1991-1995) Cases, Interviews, Archival		Examined the adoption of medical-manager hybrid roles in the context of professional role change to analyse the development of the clinical director role and de-professionalisation. Clinicians are bureaucratized through acceptance of increased commercial and managerial responsibility; are not de-professionalised. Clinical directors “maintain the occupational closure of the medical domain,” (p.150).
Owen and Phillips (2000)	Ignorance is not bliss: Doctors, managers and development	UK Management Development Programme Participants	Course questionnaires and interviews	26 questionnaires, 16 interviews	Empirical study of early career doctors enrolled on a management development programme and from across health care disciplines. Identifies doctors interest in management is neither uniform nor static and adopts a course evaluation approach. Concludes that multiple discipline involvement in courses may encourage better collaborative working in the field.
Burtonwood <i>et al.</i> (2001)	Joining them up: the challenges of organisational change in the professional politics of general practice	UK	Action Research	12 practices	Identified that GP CPD, for quality improvement generally, made little reference to organisational or local health priorities. Explore practical challenges of developing general practices to be effective inter-professional and inter-agency organisations through Senge’s phases and challenges of change. Amongst other things, identified the risk of isolating projects when development work is confined to individual responsibility.

Doolin (2001)	Doctors as Managers. New Public Management in a New Zealand Hospital	New Zealand Hospital	Interviews	'Interviews at all levels'	Examined introduction of budgets in hospitals and extent to which the clinician manager adopted manager role. Clinicians were disenfranchised managers but a few did identify with the role.
Goldie and Sheffield (2001)	New Roles and relationships in the NHS – barriers to change	Scotland	Case Study	4 Health Boards	Empirical study of the implementation of 'Designed to Care'. Found GP support for collaborative GP commissioning whether they had been fundholders or not. Fundholders were missing the benefits that they and their patients enjoyed by holding a commissioning budget. The influence of managerial domain was still found to be limited and the GPs were reluctant to exercise managerial controls over peers.
Llewellyn (2001)	Two-way Windows': Clinicians as Medical Managers	UK Hospitals	Interviews		Seeks to understand the aspirations and activities of doctors with management responsibility in the context of the 'new' area of expertise of medical- management using the metaphor of a 'two-way window'. Identifies that when professionals hold budgets but lack expertise (to control information on which budget is founded and interpreting their messages) they are able to 'devolve financial responsibility' without transferring financial control. Identified doctors may risk losing clinical visibility and respect thus presents the management tasks as supplementary thus avoiding crossing the divide into the domain of management.
Morris and Farrell (2003)	The 'Neo-Bureaucratic' State: Professionals,	UK GPs	Survey of professionals	14 from schools, 11 from social work, 7 GPs	Investigation of the impact of new governance on managers and professionals in the public sector. Critical appraisal of the assumptions made by NPM and its impact on professionals and the single sector approach to research.

	Managers and Professional Managers in Schools, General Practices and Social Work				Found GPs not desirous of management role, gained strong impression was game playing the system. Overall conclusion that impact on professional roles is that they are differentiated, mediated and not always negative.
Braithwaite (2004)	An empirically-based model for clinician-managers' behavioural routines	Australia	Longitudinal. Assimilates from three studies between 1989 and 1994. Includes participant observation, content analysis, field note mapping.		Seeks to replace normative-prescriptive accounts with aposteriori i.e. how they do manage. Presents a conceptual model of behavioural routines of clinician managers. Provides a "grounded description of clinician-managers' behavioural routines", (p. 256).
Iedema <i>et al.</i> (2004)	'It's an Interesting Conversation I'm Hearing': The Doctor as Manager	Australia Hospitals	Discourse Analysis	8 Extracts	How doctor-managers manage their position between profession and organisation.
Kurunmaki (2004)	A hybrid profession – the acquisition of management accounting	Finland Hospitals	Semi-structured interviews with	First phase: 32 people 41 meetings Second	Contrasts the intrusion of accounting practices in Finland to the UK in the context of the medical profession. Examines the calculative practices of managerial accounting in the context of Finnish NPM reforms. Doctors accept

	expertise by medical professionals		‘persons working in hospitals’ including managers, doctors, nurses. Meeting observations. Collation of documents.	phase: 13 people	accounting practice as part of their hybrid role. Financial argumentation suggested financial knowledge by the hospital doctors largely due to the lack of a formalised accounting profession to defend their domain (unlike the UK).
Rundall <i>et al.</i> (2004)	Doctor-manager relationships in the United States and the United Kingdom	United States United Kingdom Hospitals	Questionnaire		Comparative study looking at the strained relationship between doctor and managers in hospitals rather than doctors as managers. Recommended doctors should become more involved in decision making especially resource related decision. Both countries showed pessimism on the state of the doctor –manager relationship.
Hannah <i>et al.</i> (2005)	Attempts to Improve Accountability in Primary Health Care: Evidence for a GP Practice in Scotland	UK General Practice	Case study: Interviews, Documents, Observation	Single Practice	Considered the organisational restructuring of general practice under various government reforms to highlight ways that the single practice had been shaped. Found that reforms represented financial control rather than improvement in accountability. GPs considered financial management important but had no interest in ‘financial details’ but researchers did not look at the individual GP as a unit of analysis rather the practice group.
Jacobs (2005)	Hybridisation or Polarisation: Doctors and	UK Germany Italy	Multi-site, Multi-country	21 interviews clinical staff	Explores medical profession and accounting practices. Extends Kurunmaki (2004) to other European countries. Uses education as the indicator of hybridisation i.e. has

	Accounting in the UK, Germany and Italy	Education	case study. Document examination followed by semi-structured interviews	in hospitals	accounting become part of the curricula. This is found not to be the case but medical managers absorb the accounting and hence the evidence concludes polarisation. Concludes that the level of hybridisation is weakest where the accounting profession is strong in a country.
Degeling <i>et al.</i> (2006)	Clinicians and the governance of hospitals: a cross cultural perspective on relations between professions and management	Australia, England, New Zealand, China Hospital		2637	There were cultural differences between professionals and organisation.
Fitzgerald <i>et al.</i> (2006)	Managing Change and Role Enactment in the Professional Organisation	UK Hospital And PCTs	Comparative Case Studies	11 (6 acute sector and 5 PCTs). 175 semi-structured interviews	Key question of how clinical directors and service managers from non-clinical backgrounds interpret and enact their roles. Enactment defined as activities, tasks and decisions taken by the role holder in the organisational context. Focus on role definition. Hybrid manager roles were analysed from an organisational strategic perspective. Hybrid manger roles important in the change process but are primarily part-time. Clinical managers do not wish to remain in management. Called for more research in why hybrids do continue in a management role.
Clark & Armit (2008)	Attainment of Competency in Management and Leadership: No	UK Education	Literature Review, Interviews	Unclear	Educating doctors in management. Some management and leadership included in medical school curricula. There is an emerging competency framework.

	longer an optional extra for doctors				
Kirkpatrick <i>et al.</i> (2009)	Medicine and Management in a Comparative Perspective; the case of Denmark and England	Denmark England Hospital		Secondary data sources	Recognises health reform trend for doctors participating in management. Notes similarities and timings in two European countries but different response by the profession. A more positive response in Denmark. Strong focus on power relationships.
Ostergren (2009)	Management Control Practices and Clinician Managers: The Case of the Norwegian Health Sector	Norway Hospital	Case study of two regions: Questionnaires	42 clinicians	Questions, amongst other things, how management control systems can lead to hybridisation or polarisation of clinician managers. Found that clinicians report deviations but do not take on board the 'consequences by increasing efficiency'. Two regions had differing degrees of hybridisation. Suggests management control systems could improve in clinicians interacted with other departments to do so.
Neogy and Kirkpatrick (2009)	Medicine in Management: Lessons across Europe	UK Denmark France Netherlands Germany Italy Hospitals	Secondary supported by Primary: Interviews (one or two per country)		Aims to compare the changing role of doctors in management across 6 health systems. A key question is whether doctors have engaged with management priorities and if not why. Concentrates on formal roles in the hospital sector. Reports 'some' progress since Griffiths in getting clinicians to engage with the management agenda. And not much success in embedding management education into curriculum. Questions still raised about how clinicians engage in management roles. Accounts of national differences in relationship between medicine and management and not engagement in it.

Kippist and Fitzgerald (2009)	Organisational Professional Conflict and Hybrid Clinician Managers: The effects of dual role In Australian Health Care Organisations'	Australia Hospital	Interviews and observation	14 people on a management development programme	Examines tension between hybrid clinician managers' professional values and the organisations management objectives. Hybrid role may not bring effectiveness because of tension when clinician has to abandon hybrid role for clinical and other view increase in their workload because of less clinical staff.
Witman <i>et al.</i> (2010)	Doctors in the lead: balancing between two worlds	Netherlands Hospitals	Interviews	6 Department Heads, Colleagues (29 interviews)	Examines the leadership in a university hospital by doctors who 'bridge' the medical and management world. Sometimes they display managerial behaviour but medical habitus dominant. Clinicians are reluctant to manage; may be appointed because 'someone has to do it'.
Russell <i>et al.</i> (2010)	The Social Identity of Hospital Consultants and Managers	Ireland Hospital	Semi-structured interviews	15 Consultants	Explores consultants' social identification, how it influences their perceptions of management activity and change. Consultants thought the public viewed them negatively with management perceived, and associated with powerlessness, and lack of respect. Identification with formal management positions was unattractive. Management roles perceived to provide few opportunities to experience self-efficacy. Concludes their social identify could be under threat
Ham <i>et al.</i> (2011)	Doctors who became chief executives in the NHS: from keen amateurs to skilled	NJS Organisations in 2009	Interviews	20	To investigate experience of chief executives to understand career paths and facilitators and barriers along the way. Doctors experienced a change in identity and the role of leaders in hybrid positions is not well recognised. Call for move for keen amateurs by education through new faculty

	professionals				
O’Riordan and Mc Dermott (2012)	Clinical Managers in the Primary Care Sector: do the benefits stack up?	Ireland GPs	Mixed method using interviews from a subset of data	14 Semi-structured	Descriptive and exploratory study. Nature and value of clinical management role take by primary care doctors in Ireland. States little attention paid to it but a rising policy importance. Found that there was a need for policy consideration of the role in primary care and need for specialist management training. Recognises change management issues in the literature and points to problems of commitment, role incompatibility, role overload and power and authority hence negativity. GPs in informal, operational roles supplementing any managerial activity by delegation to practice managers. Recommends future research to take “account of a variety of structural and other contingencies that impact upon the efficacy of the role,” (p.637)

**APPENDIX 4**

Practice		A ( <i>Guardian</i> )			
Demands		Constraints		Choices	
Having to do certain kinds of work	Having to satisfy certain criteria	Internal to the Practice	External to the Practice	How the work is done	What work is done
.		<p>LP admits his dominance suggest few internal constraints, however...</p> <p>“I need a day and half with fund manager every week. I get half a day uninterrupted.”</p>	<p>Limitations of the depth of detail in activity reports e.g. wanting to know more details of spend in specialities, trends over time, projected costs.</p> <p>Technological constraints (see quote 3).</p> <p>Financial constraints through fundholding management allowance (see quote 4).</p> <p>Being viewed as s bottomless resource (see quote 5).</p>	<p>Driven by the LP according to Fund Manager.</p> <p>Appointed Fund Manager to take over from Practice Manager thus inserted another manager into the practice.</p> <p>“...spend a lot of time thinking about fundholding...”</p> <p>Receives monthly reports on budget position and asks Fund Manager what it means.</p> <p>Operates as a “team” with the fund manager.</p> <p>Receives advice by sitting</p>	<p>Initially filled all the forms in and things like contracts are in place i.e. procedural.</p> <p>Delegation of task but management of outcome e.g. turning data into information for decision making (see quote 1).</p> <p>Uses number a lot as examples. Likes to identify costs so that can argue case. Acts as negotiator (see quote 2).</p> <p>Says spends most of time on strategy, individual</p>

			Perceived inadequate budget.	<p>on various committees.</p> <p>Attends courses.</p> <p>Through developing good relationships.</p> <p>Employ non-NHS FM.</p>	<p>patient problems -</p> <p>“...working out what we can do...”</p>
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### Key Quotes

1. “...it is an awful lot easier to look at outcomes... so in that sense it gave us information that kind of thing has been useful for us to know, all changes we’ve made have been based on information and audit. I don’t think we could if we were not involved.”
2. “There are costs involved and when you have made savings then you can argue the margin and affect what’s going on and stuff like that and it has helped us...”
3. On the computer package used: “It’s not ideal. I’ve got Microsoft Office on my computer at home and it just whizzes around, it does what you say and if I knew how to use it I could make it dance. EMIS is black and white...absolutely no sophistication.”
4. “With the amount of money in the management fund you are not able to go into the market and say fine we want an all singing and all dancing person who could earn probably 50% more.”
5. “We get nothing for sitting on Health Authority committees and stuff like that you do because you are interested. I think the idea that we are a bottomless resource who can come back and see patients and do surgeries and be sued when we get it wrong and all the rest of it. I don’t think they have any idea of the onerous work load they are building up.”

Practice		B ( <i>Reluctant Innovator</i> )			
Demands		Constraints		Choices	
Having to do certain kinds of work	Having to satisfy certain criteria	Internal to the Practice	External to the Practice	How the work is done	What work is done
.		Relative to other practices, a highly developed management structure e.g. partners leading small management teams i.e. “screwed down management systems,” (LP <sub>B</sub> ).	Protecting local cottage hospital, constrained in contracting etc.  Perceived strong link between fundholding and practice management (see quote 2).	Driven by the Practice Manager.  Disaggregation of the function from the practice management as a whole (see quote 1).  Uses ‘we’ and not ‘I’.  “Really just a case of employing people to do the donkey work to administer it.” (LP <sub>B</sub> )  “ <b>Working out practically where you were going to do with a piece of paper was much more important than internal systems for shifting the paper around.</b> ” (LP <sub>B</sub> )	Tempering the aggressive practice manager; the link between management of fundholding and the patient at the heart of the main business.  Weekly management meeting of two partner and practice manager.  Says concerned with strategy, the management rather than the administration (see quote 3).  Refers to the ‘bloke in charge’ i.e. practice manager.

				<p>We get sight of a lot of the bottom line...photocopied and put them in our pigeon holes, the two lead doctors.” (LP<sub>B</sub>)</p> <p>Employ non-NHS FM and indeed practice manager one and same.</p>	
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### Key Quotes

1. With reference to the small practice management teams configured such that “instead of having fortnightly practice meetings, where no decisions were made, because everybody fell out and didn’t agree, we were then having quarterly meetings...we already had two partners in place doing technical management of the practice with the manager.”
2. “You can’t separate practice management from fundholding, and now we taken on TPP as well. It’s so closely inter-linked, each affect the other. There was no question of needing to get anybody else.”
3. On what spends most time on: “It’s really about policy decisions, about general trends, like are we going to move into the private sector?”
4. On the future: “I hate the thought of being involved even more with responsibility for accountancy if you like, and the management of practice.”

*Note: Very much story telling i.e. foreshadowing. Every question has a story in the ‘we’ sense.*

Practice		D ( <i>Guardian</i> )			
Demands		Constraints		Choices	
Having to do certain kinds of work	Having to satisfy certain criteria	Internal to the Practice	External to the Practice	How the work is done	What work is done
<p>“...there is not a great deal of training out there from a GP side of being a lead partner. I think you rely on picking bits out from inappropriate courses...learning on your feet.”</p>			<p>Lack of training.</p> <p>Inaccurate data.</p>	<p>Describes self as advisor and policeman.</p> <p>“...trying to observe that people follow guidelines that we put down for referral patterns and prescribing...”</p> <p>Says he thinks as an entrepreneur.</p> <p>Appointment of individual to computer type work – linked into to one of reasons for going fundholding for this practice and subsequently that individual appointed FM.</p> <p>Shared with another partner and then that a</p>	<p>Compliance role – an auditor role, “...important that you look at what you are doing and analyse it and be willing to change...”</p> <p>“...organise good deals for the practice...”</p> <p>“...bring in ideas...”</p> <p>Recruited staff to input data.</p> <p>For LP seems to have set administration into place in order to become the negotiator and savings seeker but without getting involved in numbers (see quote 2).</p>

				<p>partner stepped down.</p> <p>Seek good service at a good price.</p> <p>“...most staff don’t have a lot of input into fundholding...”</p> <p>Employ non-NHS FM.</p>	<p>Observation (see quote 3).</p> <p>On what he does with information from FM – “discuss it ... much more rarely I will take it away”.</p> <p>Suggest superficial and not as embedded in strategy as say practice B ... “use hem in meetings or pass information on to other partners, secretarial staff”.</p> <p>Admits spends most of time on contracting.</p>
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**Key Quotes**

1. “...trying to observe broad guidelines that we put down on referral patterns and prescribing. I think as an entrepreneur to try and organise good deals for the practice...to try to generate some fund savings. Certainly to bring in ideas.”(LP<sub>D</sub>)

2. “the administrative side of finance the actual accounting side I don’t really have a lot to do with that”
3. On what an ideal course might be: “It varies obviously from practice to practice. Some lead partners really just sign invoices I think and not much more than that. Other lead partners do do the accounting side. I can’t see much point in being a partner in a practice and doing the accounts really. And I think the role I have here is about right but yes, I have not found a course that has been a reflection of the type of job I do.”
4. Refers frequently to deal and good patient service: “we look out for the best, the most accessible deals with a high degree of clinical quality, so they undoubtedly get a good service being here”.

Practice		E ( <i>Opportunist</i> )			
Demands		Constraints		Choices	
Having to do certain kinds of work	Having to satisfy certain criteria	Internal to the Practice	External to the Practice	How the work is done	What work is done
“...all the extra paper work... (See Quote 4).		On 5 of the 6 partners wishing to leave fundholding...”because they don’t like x pending time at meetings and away from the practice. They want him to see patients and not go away from the surgery.” (FM)		<p>Evidence of sharing between LP and FM (see Quote 1).</p> <p>LP doesn’t ask for regular information, relying on the FM. (But see quote 3).</p> <p>On want they saw their role as:</p> <p>“A motivator, an innovator and perpetrator I suppose” (LP).</p> <p>LP receives lots of reports some of which is ‘binned’ and other ‘sorted at the back of his head’... “I rely on my practice manager to keep me up to date...” (see quote 5).</p> <p>Employ NHS FM.</p>	<p>Based on savings the LP “thinks of most effective way to spend the savings” (FM). Thus he is interested in outputs rather than the process of achieving the outputs???</p> <p>Negotiating and contracting with providers.</p> <p>Is also on city fundholders group i.e. on the executive.</p>

### **Key Quotes**

1. “I’m affectionately known as the boss... well, I just do it. It was put in my job description and Ken and I just do it between us” (FM)
2. On referring to external course... “he would maybe say it helped him a bit, but he’s a very good manager anyway” (FM)
3. “Oh actually that’s not true – there’s one thing he asks for on a regular basis and that’s ‘how many savings have we got left?’
4. “...all the extra paper work and for the first few years instead of getting less, it got more and we got bogged down in preparing business plans which were never read.. I think somebody actually put ‘we are going to introduce Popeye and Olive Oil in as counsellors... a complete waste of time and they were there to conform to some mythical civil servants idea how this should be run.” (LP<sub>E</sub>)
5. “I don’t need regular check-ups because I have a reliable team and I have to rely on them so if you like the 4Ds apply –decide something’s got to be done; do it yourself; delegate it and if you can’t do any – dump it.”

Practice		only FM (use as proxy)			
Demands		Constraints		Choices	
Having to do certain kinds of work	Having to satisfy certain criteria	Internal to the Practice	External to the Practice	How the work is done	What work is done
				<p>Different lead partners, changed in two years... “to enable different people to feel what it’s like and to have a go at it”</p> <p>Dissemination at meetings by the true lead – the fund manager.</p> <p>Employ NHS FM – 30 years experience</p>	<p>Used to meet with all partners regularly but then it fell to two lead partners and then reduced just to a quarterly update.</p> <p>Yearly awareness on fundholding session by FM.</p> <p>When asked what lead partner does with that information (see quote 1).</p>

### Key Quotes

1. “Hopefully he absorbs the blessed stuff and remembers it! But basically he will save that for when is in a meeting with providers and when there is any negotiation with providers, and for discussing matters with other members of the partnership who are obviously not lead partners.”

Practice		H ( <i>Opportunist</i> )			
Demands		Constraints		Choices	
Having to do certain kinds of work	Having to satisfy certain criteria	Internal to the Practice	External to the Practice	How the work is done	What work is done
Refers to core values (see quote in Ch 6 and 2 below)		Partner trouble (see quote 1) “There’s still some strain within the practice	Swamped with information	Networked with other fundholders (FM)  Employment that is non-NHS (FM)	Preparing own report one sheet management (LP) Key quote 3  Key quote 4

### Key Quotes

1. “There was a bit of a problem a little while ago perhaps, where it was me versus the partner, but that has been resolved now after a couple of vibrant partners meetings where I put to them the problem which the partnership has and we, as a partnership, are going to solve it.” (LP)
2. “... you can’t just dawdle around and have another meeting because you’ve patient to see and you’ve got to deal with it” (LP)
3. Long quote “... put it all... one sheet management” (LP)
4. Long quote “... become more streamline, more efficient... commissioning activity.” (LP)

Practice		I ( <i>Guardian</i> )			
Demands		Constraints		Choices	
Having to do certain kinds of work	Having to satisfy certain criteria	Internal to the Practice	External to the Practice	How the work is done	What work is done
		Internal expert evidence emerges 2, 4, 5		See 1,2, 3 below Financial responsibility and service development.	Taking matters to other partners. FM does all finance related (see quote 2). As a fundholding practice (see quote 4). Organic growth (see quote 5).

### Key Quotes

1. "...with as little disruption to the normal running of the practice as possible, primarily because the GPs that were anti-fundholding didn't want to see it making a difference" (FM<sub>1</sub>)
2. "[I am] the odd job man. Basically I do everything to do with any kind of finance...IT, maintenance, commissioning, all the lot ..." (FM<sub>1</sub>)
3. "...it was felt we could just run fundholding in the background with very little change in the clinical experience [initially]...prior general manager from non-medical background...great difficulty adapting to NHS culture..." (LP<sub>1</sub>)

5. Cannot be done despite initial enthusiasm to do so...It very quickly became thought of as a central theme of the practice, we were a fundholding practice and this is what the practice was about (LP<sub>1</sub>)

5. Critical aspects were deemed to be good contracting, good negotiating and a cornerstone really, keeping your priorities clinical, having a view to quality as well as cost. I would have identified those people [being key staff] much more clearly and identified their tasks much more clearly instead of letting it grow in this sort of organic way that it did (LP<sub>1</sub>)

Practice		J (Opportunist)			
Demands		Constraints		Choices	
Having to do certain kinds of work	Having to satisfy certain criteria	Internal to the Practice	External to the Practice	How the work is done	What work is done
		None as a balance of work between partners according to LP - democratic		<p>“Reading excellent summaries”.</p> <p>Work done equally amongst partners</p> <p>Little change (see quote 2).</p> <p>Delegation to fund an practice manager</p>	Receives information every month

### Key Quotes

1. I think fundholding helped them to come to terms that they needed a proper manager...and to let go of those traditional roles that each GP had...they've a more structured management team and really the management skills they lacked as GPs , their responsibility has been passed on to the managers to manage rather than them doing it. (FM<sub>J</sub>)
2. Data collection...it just slid in very gently and what we did was we shielded the partners as much as possible...minimal amount of change imposed on the practice by fundholding. (LP<sub>J</sub>)

3. I used to spend time looking at individual contracts, I now basically just read the excellent summaries...exactly the position where we are... delegation is the name of the game...I just give a touch every now and then just to make sure things are going right...clinical stuff comes first then the other stuff comes later. (LP<sub>1</sub>)

Practice		L ( <i>Opportunist</i> )			
Demands		Constraints		Choices	
Having to do certain kinds of work	Having to satisfy certain criteria	Internal to the Practice	External to the Practice	How the work is done	What work is done
				No evidence proffered.	Uses the word 'we' a lot but does not elaborate on how or what is done.

**Key quotes**

1. ...ball was left with me to start playing with it as I wanted. (LP<sub>L</sub>)
2. We analyse, at the end of each month, when the accounts have been closed we go through the financial statements, we go through our waiting list, we go through the priority list...a batch of reports...I am very pleasantly encouraged with the information that I have been receiving through my contracts manager...spend most of time on management of lists and make sure that we are not overspending. (LP<sub>L</sub>)

Practice		M ( <i>Reluctant Innovator</i> )			
Demands		Constraints		Choices	
Having to do certain kinds of work	Having to satisfy certain criteria	Internal to the Practice	External to the Practice	How the work is done	What work is done
				Delegation on the face of it then apparent working with fund manager	Said left to fund/contract manager but then refers to using information for analysis.  Site expansion and entrepreneurial activity.  Personal role expanding

### Key quotes

1. ...there's no point me wasting time entering referrals and messing about with reports and things.....to be quite honest and say that I do allow my fund manager. Contract manager to largely get on with things... he looks at budgets and things. What he will do is report to me, so I monitor what's going on... some GPs are much more into contracting side which I'm not (LP<sub>M</sub>)
2. I look at it (laughter), look at all these figure and, no what we do is if we're looking as though we're going to overspend which happened last year , we'll deliberately stop the hospital operating...keep an eye on prescribing budget... so I've done the referral analysis by partner and speciality” – looks at service implications (LP<sub>M</sub>)
3. Asked directly about the aspects of management:

Critical? I think you've got to have the right manager in my view. I am not a manager, I'm a doctor, and I wasn't trained as a manager...have a fund manager that you can trust...liaising with Health Authority... keeping you informed (LP<sub>M</sub>)

Practice		N ( <i>Opportunist</i> )			
Demands		Constraints		Choices	
Having to do certain kinds of work	Having to satisfy certain criteria	Internal to the Practice	External to the Practice	How the work is done	What work is done
				Advice but not engaged in process regularly.	Grand policies only by LP

### Key Quotes

1. I don't spend too much time, once a year when the contracting process is in progress...I give them advice yes, we will have to take the contract with this provider, but not that provider. I know what my patients want... they like to go to a nearer hospital. I only make the grand policies and then I will leave it for the contract manager and the fund manager to make the final negotiations on my behalf (LP<sub>N</sub>)

2. ...In the Long term it is good for patients, it is good for the GP and it is good for the Department of Health because in the long term it will save them a lot of money. It is incentive for the doctor, not financially for themselves but for the practice, it is better. It is the incentive for the doctor to control the finances in her practice, it is hard work, but at the end of the day it pays dividends and it will be a great shame if fundholding is cancelled altogether.(LP<sub>N</sub>)

3. I don't involve myself with the software, people upstairs do...We saved on drugs, we taught ourselves the discipline of prescribing... of referring people to hospital...

4. At the end of the day fund management is about prudent financing, if you have got a good contract manager, a good fund manager who is going to negotiate good contract for you... make some saving... plough the savings next year for the service of the patients and this is very important

Practice		O ( <i>Reluctant Innovator</i> )			
Demands		Constraints		Choices	
Having to do certain kinds of work	Having to satisfy certain criteria	Internal to the Practice	External to the Practice	How the work is done	What work is done
				Informally and not clinical involvement.	Signing invoices – a franking exercise hence not in management as such.

### Key Quotes

1. I suppose if volunteered myself [laughs].(LP<sub>O</sub>)

2. I suppose information from the contract manager is more to do with figures. Nothing much clinical...we think about it and report back. There's no formal written things going backwards and forwards... I suppose it's looking at and signing invoices. It sounds very boring doesn't it really? I think that probably the main [thing I do].(LP<sub>O</sub>)

...the attitude is more laid back...practice itself is quite tranquil...everything developed slower (FM<sub>O</sub>)

3. I think they didn't realize what was required...to be honest I don't think any practice fully understands what they need to do to make fundholding work...a lot went in with their eyes closed... to be honest to make it work you don't need to be a GP and you don't need to be a practice manager...what you do need it a wide range of management experience and you need experience of working in the hospitals (FM<sub>O</sub>)

4. I think the fund manager, who is also the practice manager, is really an interface between the medical side and the accounting side.(LP<sub>0</sub>)

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