

Current Issues in the Organisation, Management and Politics of Primary Care

Professor Ewan Ferlie

Paul Thomas's interview with Lord Darzi, the Junior Health Minister, makes fascinating and thoughtful reading. We are lucky to have an eminent clinician who has chosen to make a transition into the very different world of health politics. More broadly, the involvement of senior clinicians in national level health policy work (for example, the 'Czars') has been a creative development in the New Labour years in bridging the conventional divides between the different worlds of health care professionals, managers and politicians. No doubt different commentators will analyse the interview with distinctive pairs of eyes. My own interest lies in the broad organisation and management of health care, here primary care, and it is here that I advance some observations.

Although there have been various 'Darzi reviews', the term is most usually associated with the policy drive towards larger scale primary care polyclinics. London is seen as a possible pilot area, given its urban geography. The policy is highly politically controversial, as will be considered later. Darzi here clarifies that he is more interested in the wider idea than a building and that there are different ways of moving towards the polyclinic model, such as federating practices, depending on local circumstances. He stresses that he believes in bottom up forms of organisational change. Such organic local developments, however, are long term and require local negotiation: so they are unlikely to deliver major change rapidly. A second danger is that the new buildings for polyclinics will in the end – perhaps in an unintended fashion - become an expensive and capital led distraction. But surely the broad intent to 'clump together' primary and social care services in larger scale units which have some scope and scale (and also an opportunity to move out of the isolation associated with very small units and so engage in effective learning and service improvement) is sensible, and builds on existing policy.

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There are in my view three wider organisational and managerial themes beyond the immediate focus on poly clinics which are also apparent in the text.

The first is whether the text clarifies the main current directions in health policy, at least within the primary care field. A criticism of current Ministers is that they have not been political enough, at least in the wider and more noble use of the term. They do not seem to be making high impact speeches about the clear and fundamental principles of health policy they espouse. Do they still believe in the principles of diversity, choice and competition in health care apparent in the late Blair governments? Or are we shifting back to alternative (early Blair) models of managed networks, integrated care and redesigned and hence planned patient pathways? Or is there a pragmatic (and possibly contradictory) oscillation between the two modes? These wider questions play out in the important primary care field. The text suggests Darzi at least is attached to the latter rather than

the former model. The phrase ‘patient choice’ does not appear widely, or indeed at all. Nor – despite what critics on the left have argued – is there any discourse about the privatisation of primary care. Instead Darzi defines his fundamental principles as follows: *‘integrated patient centred care which I’ve described as personalised care, which is care tailored around the needs of the patient.’* The personalisation of care, if achieved, might head off public demands for quasi markets and choice as more radical instruments for service improvement. There are of course huge challenges in achieving this in, for example, major areas such as elderly care services which are currently dominated by a rationing and resource agenda rather than effective personalisation. There are indeed very few resources available to be case managed or ‘personalised’.

A second broad theme is the use of organisational and managerial research in policy making. Intriguingly, the interview suggests that at least some organisational ideas and writing have been strongly appropriated by at least one Minister. Darzi refers to the need for evidence based policy and academic involvement in health care. This is conventionally seen as referring to biomedical research but we can also ask: how does organisational and managerial research and writing affect health care policy, including at a very senior Ministerial level? Usually, we assume that such research has very little impact indeed as health care managers who might be thought to be the prime audience generally have neither the time nor the skills to access and read such research. Maybe the appointment of clinicians who have been brought up in a (bio medical) research culture into hybrid policy making roles will lead to a change for the better. They may be instinctively more likely to look not only for empirical evidence, but also concepts and ideas to support policy making. There are references in the text, for example, to problems of change resistance, the principles of service redesign and the NHS as a complex adaptive system, all of which come out of organisational research. It is the fundamental ideas rather than the empirical findings that appear to have been most influential.

Thirdly, what does the interview tell us of the current politics of primary health care? All Ministers are in the end political appointments, however expert and evidence based they be. Health policy proposals have (rightfully) to survive tough contest

in the political arena as well as be evidence based. A health service funded by taxpayers will and indeed should produce an intense politics of health policy. There are fundamental issues of health politics as well as organisation and management. The polyclinic proposals are highly politically controversial and Darzi uses the interview as an opportunity to put on record what he is proposing. Is he here reacting to Cameron’s recent speech on primary care to the King’s Fund?

Cameron’s speech set out broad political principles and repays study. Cameron stressed the need for personal contact, local access and continuity of care as guiding principles in primary care. He argues for the greater devolution of power to professionals especially GPs and a retreat from top down micro management (although target setting, profession bashing and frequent structural reorganisation started in the 1979-1997 Conservative governments; only to be continued by New Labour).

Cameron argued that he was not against polyclinics in principle but that:

‘where they occur, they should occur naturally, as in the voluntary combination of free agents – not as the latest structural reorganisation of the NHS. Lord Darzi, the health minister behind the polyclinics plan has admitted that doctors will, effectively, be forced to polyclinics using the GP contract. It is quite wrong.’

Was this really to be seen as some short term political excitement in advance of the London Mayor elections? Cameron states he is not against the local adoption of the polyclinic model. In this interview, Darzi clarifies that he is favour of bottom up forms of organisational change and that the federated practice model is one mechanism. Does this rule out forced merger? Maybe it will over time be possible to achieve a greater degree of political consensus around polyclinics than is apparent at the moment. This will of course be necessary if the idea is to survive any change of government in the future.