# The impact of economic rationalism and new public management on health and welfare provision: accounting for the gap between social health care policy and practice in two Scottish maternity care units.

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## Declaration

I declare that this thesis has been composed by myself and that the work is entirely my own and has not been submitted for any other degree or professional qualification.

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# Abstract

The administration of welfare in Britain and beyond, in the last thirty years, has seen a series of changes culminating in the new public management (NPM) approach in the delivery of public services. Current literature suggests that traditional collectivist values underlying state welfarism are at risk under the precepts of NPM and economic rationalism (Hood 1991; Clarke and Newman 1997; Hunter 2002). Since rigid economic calculation is not always possible or rational on a social, psychological, or medical scale, social policy prescriptions have to bend to its calculative pulse. Selecting decentralised budget management as one key aspect of NPM, this thesis tests out its impact on two key social health policy recommendations, 'service user choice' and 'continuity of care' as set out by *Changing Childbirth* (1993).

The design of the study consists of a merger of two distinct methodological approaches: questions put to participants were informed by a NPM framework; at the same time, the openness of the interview schedule enabled issues and themes to evolve in a grounded way. The study took place in Scotland where two highly contrasting maternity units, in terms of size, internal culture, and geographical location, were investigated. Tape-recorded in-depth interviews, of around 45-90 minutes each, were carried out with a sample of 43 consultant obstetricians, junior doctors, paediatricians, midwives, and key financial management personnel.

The comparison of the two sites highlights how organisational size, structure and the midwifery system in place can impinge on the viability and implementation of social health policies such as those recommended in the Cumberledge Report (1993).[1] Whilst constrained budgetary procedures have hampered the full expression of service user choice and continuity of care, largely due to inadequate staffing or practitioner skills, the dictates of new public management have had a more turbulent impact on the larger than on the smaller unit.

One finding of this thesis is that service user choice is not only inhibited by economic rationalism but also by internal institutional agendas - a consideration, which, to some extent, is likely to be applicable to all health and welfare services. Another key finding is the identification of the distinct forces that combine to obstruct the implementation of social health policies. Apart from complex economic, organizational and institutional influences, one significant obstructing factor is the obstetricalisation of childbirth. The gap between social health policy and practice is widening as mergers take precedence over the retention of smaller, relatively low-tech maternity care units. This structural change designed to achieve perceived needs for 'medical safety' in an economically rational way is increasingly likely to render the recommendations of *Changing Childbirth* impracticable.

The thesis concludes that a comprehensive approach towards health and welfare, where service user choice and continuity of care are recognised, which considers the social context in which economic action takes place, could be expected to lead to improved health and welfare outcomes overall.

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[1] Cumberledge Report (1993) *Changing Childbirth* London HMSO

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LIST OF ABBREVIATIONS

| | |
|---|---|
| **AIMS** | Association for improvements in the maternity services |
| **ARM** | Artificial rupture of membranes |
| **CAM** | Complementary and Alternative Medicine |
| **CRAG** | Clinical resource audit group |
| **CTG** | Cardiotocograph: electronic monitoring of the baby's heart and mother's uterine activity |
| **CU** | Consultant Unit |
| **DFM** | Divisional Financial Manager |
| **DGM** | Divisional General Manager |
| **EFL** | External financing limit |
| **EPAU** | Early pregnancy assessment unit |
| **ER/NPM** | Economic Rationalism/New Public Management |
| **GPFH** | General Practitioner Fund Holding |
| **HIP** | Health Improvement Programme |
| **HIS** | Health Information Service |
| **IPR** | Individual Performance Review |
| **ISD** | Information and Statistical Division of the Common ServicesAgency, Scotland |
| **IUD** | Intra-uterine death |
| **LHCC** | Local Health Care Co-operatives |
| **MBI** | Management Budget Initiative |
| **MIDERS** | Midwives Information and Resource Service |

| | |
|---|---|
| **MIS** | Management Information Systems |
| **MLU** | Midwife Led Unit |
| **NCT** | National Childbirth Trust |
| **NDU** | Normal Delivery Unit |
| **NICE** | National Institute for Clinical Excellence |
| **NIE** | New Institutional Economics |
| **NPM** | New Public Management |
| **NSF** | National Service framework |
| **OMV** | Open market value |
| **PAM** | Professions Allied to Medicine |
| **PCT** | Primary Care Trust |
| **PFI** | Private Finance Initiative |
| **PPA** | Progressive Public Administration |
| **PPP** | Public Private Partnership |
| **PRP** | Pay Related Performance |
| **QA** | Quality Assurance |
| **RHA** | Regional Health Authority |
| **SBCU** | Special Baby Care Unit |
| **SHO** | Senior House Officer |
| **SNAP** | Scottish Needs Assessment Programme |
| **SPCERH** | Scottish Programme for Clinical Effectiveness in Reproductive Health |
| **TENS** | Transcutaneous Electrical Nerve Stimulation |
| **TIP** | Trust implementation programme |

| | |
|---|---|
| **TQM** | Total Quality Management |
| **VE** | Ventouse (vacuum) extraction |
| **WTE** | Whole time equivalent |

# GLOSSARY

**Antenatal care**: Care of women during pregnancy by doctors and midwives in order to predict and detect problems with the mother or the unborn child. Advice is also offered on other matters relevant to pregnancy and birth.

**Antenatal clinic**: A clinic in a maternity unit where care is provided by midwives, obstetricians and other health professionals.

**Average duration of stay (hospital)** The average duration of stay (hospital) is calculated by dividing the number of inpatient days in the hospital by the number of inpatient discharges from the hospital.

**Birthing centre:** A home like environment where a woman can give birth within a maternity unit and receive intrapartum and postnatal care from midwives and doctors.

**Birth plan:** A written record of a woman's preferences for her care and that of the unborn child during labour and childbirth.

**Caesarean section:** An operation by which the baby is delivered through an incision in the abdominal wall and uterus.

**Care giver:** A health professional providing services for a service user

**Clinical governance:** Corporate accountability for clinical performance applied to all patient services in the NHS and to services commissioned from other organisations.

**Costs:** (i) *direct costs* include medical, midwifery, pharmacy, PAM, theatre, laboratories and other staff and supplies. (ii) *allocated costs* include administration, teaching, catering, bedding and linen, laundry, patients' clothing, uniforms, portering, residences, waste disposal, transport and travel, property maintenance,

cleaning, heating, rent and rates, furniture and other equipment purchase, rental and repairs, depreciation, notional interest and miscellaneous. (iii) *gross costs* include both direct and allocated costs and exclude related income directly generated as a result of a particular episode. In most cases income ranges from 3% to 10% *(Adapted from Costs Book definition, 2000*).

**Day case:** A service user who makes a planned attendance to the maternity unit for clinical care, sees a health practitioner and requires the use of a bed. The service user is not planned to and does not remain overnight *(Adapted from Costs Book definition, 2000*)

**Delivery suite:** The labour ward in a maternity unit.

**Domino:** Abbreviation of "domiciliary in/out." This is a model of maternity care in which women are taken to hospital in labour by their own midwife who delivers them and then transfers them home shortly after birth.

**Epidural analgesia (anaesthetic or analgesia):** A local anaesthetic injected around the spinal sac causing some numbness in the lower part of the body. It relieves labour pains.

**Evidence-based practice:** The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients[1].

**High-risk pregnancy**: A pregnancy in which a risk of complication is evident or in which a complication occurs.

**Inpatien**t: A service user who occupies an available staffed bed in hospital and remains there overnight. However, a mother who delivers in hospital is also regarded as inpatient regardless of how long she stays. *(Adapted from Costs Book definition, 2000*).

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[1] Derived from Sacket, D. L., Rosenberg, W. S., Muir, J. A., Haynes, R. B. Richardson,W. S. (1996) Evidence-based medicine: what it is and what it isn't *British Medical Journal* 32 (13):71-2

**Integrated care:** A pattern of midwifery care in which the midwife provides care within the hospital and community setting for the purpose of facilitating continuity of care and improved job satisfaction for the midwife.

**Intervention:** Clinical procedure in pregnancy or labour, for example induction of labour or delivery of a baby with the aid of instruments, or by caesarean section.

**Intrapartum:** During labour.

**Labour ward:** A suite of rooms set aside in a maternity unit for care of women in labour.

**Lead professional:** The professional who gives a substantial part of the care personally and who is responsible for ensuring that the woman has access to care from other professionals, as appropriate.

**Maternity record:** A written record of the care received by the pregnant woman.

**Maternity unit:** A building or group of buildings in which maternity care is provided. It can be located within or adjacent to a general hospital, or away from other hospital services.

**Midwife**: A person registered to practice midwifery.

**Midwife led unit:** A unit e.g. labour ward, in which the pattern of normal midwifery care is planned, implemented and evaluated by teams of midwives usually led by a midwife who may be called a midwife 'consultant'. Service users are referred to obstetric colleagues on the detection of abnormality.

**Multiparous:** Awoman who has had one or more children.

**Named midwife**: It is a Patient's Charter Standard that a woman should have a named, qualified midwife who will be responsible for her midwifery care.

**Neonatal**: Refers to the first 28 days after birth.

**New attendances:** This is the first contact between the service user and the health care professional following a referral *(Adapted from Costs Book definition, 2000)*.

**Obstetric unit:** A maternity unit.

**Parentcraft classes**: Antenatal education classes.

**Perinatal**: The time of birth and the first week of life.

**Postnatal/postpartum**: Pertaining to the few weeks after birth.

**Primagravida:** A woman pregnant for the first time.

**Primiparous:** A woman who has given birth to her first baby.

**Puerperium:** The six weeks immediately after childbirth.

**Revenue expenditure** Running costs which consist of pay, supplies and services in providing a maternity service.

**Team midwifery**: A designated group of midwives within or outwith the hospital who practise as a team in order to provide care to a designated group of women.

**User/service user:** A consumer of the maternity services; the pregnant woman.

**Venepuncture**: Intravenous injection for blood sampling.

# OVERVIEW OF SITES VISITED DURING FIELDWORK

## BELLHAM TRUST

### Bingham maternity unit

- Approx. 1,492 births p.a.
- 4 consultants
- 60 midwives
- 28 ante/post natal beds
- 6 labour ward rooms
- 12 cots
- No SBCU
- 1 theatre
- Team midwifery system
- Integrated midwifery
- One budget holding team

**13 participants**

*12 miles apart*

### Warnick Maternity Unit

- Approx. 1,600 births p.a.
- 94 hospital midwives
- 16 community midwives
- SBCU 5 beds
- Fragmented midwifery system

- **5 participants**

## CRAIGHILL TRUST

### Crighton maternity unit

- Approx. 6,418 births p.a.
- 13 consultants (WTE)
- 323 midwives (head count)
- 2 community midwife teams
- 90 ante/postnatal beds
- 14 labour ward beds
- 40 cots
- NDU 3 beds
- HDU 4 beds
- 2 theatres
- Training hospital
- Fragmented midwifery system
- Budget-holding hierarchy

- **25 participants**

# Chapter one

## Introduction

### *1.1 The focal question*

The widespread view that there is a crisis in the contemporary provision of welfare has been attributed to the failure of public expenditure to keep up with its funding requirements. This crisis, however, is also a crisis of values. Are principles, which have traditionally underlined the provision of welfare retreating, as neo-liberalism marches forward? This two-pronged dilemma where cash competes with care forms the core of this enquiry. Is British social policy being driven by a regime that is entirely underscored by economic rationalism (ER)? If so, how are the values underlying social and health care policies interpreted and implemented within a financially restricted managerialist framework?

### *1.2 The conceptual framework*

In order to answer this central question, the study investigates one area of health viz. maternity care. The enquiry tests out whether findings are consistent with a conceptual framework that places economic rationalism and new public management (ER/NPM) at the centre of the transformations in the wider field of health and welfare services. There has always been a problem of a gap between policy and practice, but has the switch from the old welfare ethic to the new managerialist code widened the implementation gap even further?

In Britain, the welfare state grew during a period of post-war consensus that halted with the recession of the 1970s. As the goals of social policy reformers and the

context in which they operated began to change, the 'universalist welfare state' was replaced by a new paradigm, 'the affordable welfare state' (George and Miller 1994). Critics claim that the inception of New Public Management has usurped the progressive public administration of old leading to a de-democratisation of earlier forms of welfare provision. The imposition of economic efficiency above all else has resulted in a rapid disintegration of public service provision in some areas and a destabilization of traditional public service values (Hood 1991; Pollitt 1993; Walsh 1995; Clarke and Newman 1997). The outcome for social policies[1] and by extension Social Policy, as a discipline, is confusion over values. Values traditionally associated with public services and public service providers, 'the public good' and public means of delivery (James 1994), conflict with values that support the privatisation of as many parts of welfare as is politically possible.

The focus of this qualitative study is shaped by academic debates and theoretical approaches surrounding NPM. At a substantive level, the thesis raises some important questions about the link between financial management and social welfare as expressed through the relationship between decision makers who devolve and allocate budgets and health and welfare professionals responsible for both budgets and the quality of service delivery. In recent times, the hypothetical speculations of classical economic theory have had more sway than stark social realities such as poverty, homelessness and ill health. The down-to-earth sociological economics that props up the study of Social Policy is very different from the economic rationalism that presumes that the swift establishment of the Welfare State has had harmful economic consequences. Pierson (1994) puts forward that the welfare state is not seen as the victim of poor economic performance but as one of its causes. For some social policy analysts, this perspective is perceived as a deep distortion.

George and Miller (1994) explain that the balance between need and funding as determinants of provision has shifted towards the latter. The role of funding has become more explicit and the onset of economic rationalism and its various new

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[1] Defined here as 'the activities of service providers whose services are shaped by legislation and largely funded by government'.

managerial tools borrowed from the private sector has been corroding the original collectivist values. This enquiry explores how the pressure for economic efficiency impact on traditional public service values of health care practitioners and gathers some insights into actual public service provision for users of maternity care.

The NHS has been the target of a number of organisational, structural, administrative and, not least, fiscal changes especially since the publication of Griffiths in 1983, a report that can be described as the template of the new public management in the NHS. One of the intended outcomes of NPM has been to promote consumer choice and to curb professional and bureaucratic powers. This study also seeks to find out how medical and other health care practitioners fare within this new 'affordable' health care system.

The many elements of ER/NPM are discussed extensively in chapter three. Some of the measures aimed to bring about quality and achieve value have been identified as: devolved budgets (with their accompanying mission statements, business plans and managerial autonomy); accountingization (with its focus on productivity: inputs and outputs); internal markets; fiscal prudence (for example, the increasing number of short term contracts, performance-related pay and individualised job contracts); measurable standards of performance (using comparative databases for external audit, performance review and benchmarking); a decrease in trust by the state towards professional expertise. Dedemocratisation and increased central control are perceived as two key features of the new managerialism with its substitution of econo-legal principles for traditional administrative law. Broadbent and Laughlin (2002), for example, suggest that the accounting logic of public services creates certain visibilities and downplays anything else which is not deemed important. This observation raises the question of hidden agendas. The impact of NPM in the UK has meant that health and welfare services have become more businesslike. On the one hand there is an increase in managerial responsibility but on the other political accountability has been attenuated.

The findings of this study are matched up with the various contributions made by prominent critics of NPM. Whilst care has been taken to ensure empirical rigour and

reliability, the study only focuses on two settings and, therefore, there can be no outright claim to generalisability. The study does, however, deal with key variables common to all maternity units such as the need for efficiency savings, the expectation to stay within financial targets and the need for quality assurance considerations following the recommendations in *Changing Childbirth* (1993). It is possible, therefore, for other maternity units to gain fresh insights that will be applicable to their organisation as well.

### *1.3 Background to the focal theory – Cumberledge and decentralised budgets*

Alongside various changes in the organisation of the health service, an inquiry into maternity services by the House of Commons Health Committee in 1992 signalled a significant departure from the policies advocated by many previous committees of enquiry when it noted that,

> "Given the absence of conclusive evidence, it is no longer acceptable that the pattern of maternity care provision should be driven by presumptions about the applicability of a medical model of care on unproven assertions" (House of Commons Health Committee, 1992).

A year later *Changing Childbirth* reported:

> "Good maternity care will be built on trust between professionals and women and between the professionals themselves" (Cumberledge Report 1993).

*Changing Childbirth*, sometimes referred to as the Cumberledge Report (1993) outlines a number of recommendations which highlight the need for women to make choices and to be given the best possible care and support based on their needs. For many observers in and outside the UK, the implementation of *Changing Childbirth* epitomises the democratisation of maternity care in practice. In brief, the report recommends that: i. care should be woman-focused ii. readily accessible and iii. responsive and effective. It also advises that women should be involved in the planning of the service. More specifically, the report proposes that women should

have sufficient information made available to them and that they would choose the place of birth and the type of care received. Furthermore, women are entitled to a named midwife or lead professional who would help them develop a birth plan and who would facilitate continuity of care and the development of trust between him/herself and the service user. Policy documents such as *Changing Childbirth* are often underlined by democratic concepts that retain the social welfare rhetoric based on citizenship and compassion. Yet, recent literature (Stewart and Ranson 1988; Stewart and Walsh 1992; Clarke and Newman 1997; Walsh 1995) suggests that the public service management revolution appears to be overriding such values. It is the examination of this claim vis a vis *Changing Childbirth* which this study seeks to examine. What is the impact of NPM on staff cultures and expectations of quality of care taking into account the recommendations made by House of Commons Health Committee (1992) and Cumberledge (1993)?

According to George and Miller (1994), the NHS faces the threat of under-funding and state control through target setting and tough management. One of the outcomes is the crisis of confidence in the means of existing service delivery systems to manage the overload effectively. One way of making public sector workers accountable has been through the budgetary process. For health care practitioners, this has meant a rigid focus on financial information as budgeting and accounting systems define the nature and volume of their tasks as well as the evaluation of the health care they deliver. In-depth interviews with a number of budget holders in the two case study settings reveal valuable insights into the budgetary process.

Within public sector organisations, implementation of policies is a complex process. Lipsky (1980) provides a studied explanation of how and why street level bureaucrats fail to put policies into practice. Public sector reforms, such as the new public management, however, are likely to create a hierarchy of policies that stretch the implementation gap of low priority policies even further. How do social health policies fare as attention is shifted towards constant new rulings and the efficient distribution of time and money? This study explores whether the procedures of NPM has made the implementation of *Changing Childbirth* more or less difficult and

delivers some input into whether certain organisational structures assist or obstruct such social health care policy recommendations with their accent on service user choice and other needs.

### *1.4 Collecting the data: the interpretative methodology*

The inquiry uses an interpretive methodology aimed at bringing out understanding at two levels: the organisational interpretation of *Changing Childbirth* 1993; and the individual health practitioner's understanding of the complexities surrounding the concept of service user choice and continuity of care. The study aims to add to the knowledge of the way practitioners cope with two conflicting models of care: the recommendation to attend to service user needs against the imposition of constrained working conditions and cost consciousness. Delving into these contextual complexities is best served by ethnographic accounts that are likely to be more insightful than purely positivistic methodologies. The precepts of economic rationalism, as expressed through NPM, shape the nature of the questions put to the participants. An overview of the method and range of services provided by each maternity care unit was made in order to evaluate the distinct ways in which service provision is organised and funded. The study also considers the impact of the size of the two case-study settings and their midwifery systems in place.

### *1.5 Contributions*

This thesis identifies some of the factors that explain the gap between policy and practice. It also informs which influences, other than the economic rationalism, have some bearing on the way policies are translated in practice.

- It clarifies how NPM works in practice in maternity care settings and points out why generalised perceptions of the managerial model need to be modified.

- It examines internal institutional agendas, apart from ER/NPM that throw light on some important contradictions in the provision of maternity care.

- It identifies specific elements of the model that can be applied to wider health and welfare settings.

- It outlines the relationship and, in particular, the schisms that exist between economic and maternity care goals and suggests some solutions.

### *1.6. Structure of thesis*

Following a brief introductory chapter outlining the objectives of this study, the second chapter reviews developments in social and health policy during the last three decades. It outlines the macro reforms in health organisation and management in the eighties and the continuing trend to the present day. This chapter serves both as a contextual backdrop to and rationale for the maternity care fieldwork. The third chapter encompasses the theoretical framework. It discusses relevant theoretical work and bodies of literature that explain how and why Social Policy has become increasingly dominated by economic thinking. It examines new public management tactics and the accountingisation processes and discusses the effects of budgeting and professional tribalism on social health policy implementation. Chapter four gives a methodological account of the research describing the way the enquiry was designed and conducted. Chapters five and six comprise of an analysis of the research findings from the two case-study settings. Oral and statistical evidence is integrated with evidence from other relevant studies to examine key themes, service user choice and continuity of care, which emerged from the interview data. Drawing evidence from the two sites, chapter seven discusses the influence of ER/NPM on maternity care provision, in particular, the grounds for centralising maternity services and the anomalous consequences of these structural changes on social health care policies. Chapter eight looks closely at the financial and budgeting strategies of the two sites and the distinct way in which each unit has responded to the impact of ER/NPM. One particular focus is how their distinct organisational framework shapes the availability of service user choice and continuity of care. It also includes a discussion on how the roles and values of midwives and obstetricians in each unit can increase

or decrease the gap in social health care policy and practice thus developing further themes emerging from chapters five and six.

The final chapter gives a brief overview of the thesis, outlines its contributions, and draws some implications for future social and social health policy.

# Chapter two

## The rationale: directions in health and social policies in Britain

### *2.1 Introduction*

This chapter begins by looking at national trends in social policy during the last 30 years or so focusing in particular on the management and administration of health policy. The Griffiths Report (1983), which represents new public management in the NHS, is given special focus. The chapter looks at some key developments in health care organisation such as internal markets, fund holding, clinical governance, the new NHS, public-private partnerships, and consumer choice. Linked to all these reforms is the business management ethic which has become a universal code for the provision of welfare services not only in Britain but worldwide.

### *2.2 Trends in social policy in the last 30 years*

This section traces the development of the welfare state since the 1970s. An increase in public spending after the Second World War meant an expansion of mass-scale public services and public providers, in particular, nationalised industries and local government. Of key importance to the discussion that follows is the interdependency that gradually grew between government and society. With the forging of this relationship came the development of a number of citizen and welfare rights and expectations.

By the early 1970s however, the growth of the welfare state began to slow down. As the international economy went into recession, calls for efficiency resulted in

government cutbacks. This decade saw the death of consensus politics - a concept strongly tied with the growth of the welfare state. Even the Labour Government was prepared to carry out a U-turn. Automatic annual growth came to an end and rapid inflation and growing unemployment came into sharp focus. The result was a high degree of conflict between government and trade unions with the latter effectively unseating both the Conservative Government in 1974 and the Labour Government in 1979. It was during this period that the NHS was reorganised[1] in the hope of making it run more efficiently.

Both Conservative and Labour Governments during the seventies began to adopt strict funding constraints, with the Conservatives more openly abandoning the collectivist programme as the cost of welfare provision was increasingly seen as an intolerable burden on the economy. In 1975, the Labour government, deep in financial crisis, had a difficult balancing act to perform between keeping the economy growing and developing the welfare state. The government, therefore, adopted a monetarist policy of retrenchment in public expenditure. Even left wing politicians displayed a certain amount of disillusionment with welfare policies and institutions which failed to abolish poverty and other social problems.

It was these earlier developments[2] which paved the way for the New Right ideology to breathe freely between 1979 and 1997. A key element of this ideology may be described as economic freedom that is associated with nineteenth-century liberalism. Public sector reform focused on government organisations which "were increasingly seen to be stagnant, inefficient, unresponsive to consumer or individual choice, unadaptable and hostile to enterprise" (Baldry 1990:3). The outcome was an outright rejection of Keynesian short-run demand management, an introduction of supply-side policies to free up markets, an abandonment of price controls and incomes policies and an emphasis upon financial management and control of money supply.

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[1] This is a reference to the NHS Reorganisation Act 1973

[2] Accounts which chart social policy changes of the Conservative government can be found in Pierson (1996); Timmons (1996); Glennester and Hills (1998); Hughes and Laws (1998); Jones and McGregor (1998); Pierson (1998).

These measures led to substantial reductions of public expenditure and the distancing from the collectivist values of the welfare state. This decreased intervention by governments was aptly described as 'rolling back the frontiers of the state' and in the process changing the relationship between the citizen and the state. The section which follows traces the historical development of the NHS during the Conservative administration.

### *2.3 The NHS – a historical overview*

In 1974, a major reorganisation of the NHS was meant to bring about consensus management at regional, area and district levels. By 1979, the focus was on decentralisation and the reduction of bureaucracy. However, by 1982, a renewed emphasis on centralisation and the strategic role of management gained in importance. In 1982 further re-organisation abolished the area tier from health service structure and the devolved planning functions went to the to new District Health Authorities or Health Boards.

Throughout the 1980s, the market made inroads into the NHS through various forms of privatisation. Competitive tendering through internal markets and contracting out of in-house services such as cleaning, catering and portering, also led to the steady expansion of managerialism. Between 1989 and 1994 the number of NHS managers in Scotland alone increased fivefold (Paton 1999). A chief executive of a mental health trust in England described how in 1986 the finance department was very small, but, following the changes, the department increased the number of accountants, added on a business systems team and an information systems team which all involved considerable costs (Paton 1999). At the same time, the overall number of nurses employed in the UK decreased by 29 per cent (The Herald, 18 January 1996).

As will be seen in the discussion later in this chapter, this new managerialism has been put forward as a politically neutral system so that issues, which are highly political, are portrayed as objective and technical. The rush to achieve a 'competitive edge' has resulted in "a continual drive for cost-cutting, demoralisation for many

welfare workers and an explosion in the role of 'consultants'" (Paton 1999). The major consequence of these developments was to drive down wages and employment conditions of workers who were already among some of the most poorly paid in the country.

Since the inception of the NHS in 1948, hospitals have been criticised for the financial burden they incur and how the demand for services impose an organisational strain on them. An ageing population has often been perceived as a key culprit causing high running costs, whilst the power of clinicians and the endless deployment of higher technologies have also been offered as explanations for high costs, organisational fragmentation and dystopia. Before cash limits were imposed in 1976/7, the basic form of hospital archetypes were directly managed, but later in 1983, work force limits were also set and hotel, domestic services, and catering functions were expected to be put out to competitive tender (Harrison and Dixon 2000). This market-based philosophy was seen as seriously clashing with NHS philosophy.

1984 saw the launching of cost improvement programmes. Calculation on progress was to be demonstrated through performance indicators and medical audit. Performance indicators cover various quantitative measures, for example, length of patient stay and cost of laundry. These indicators are meant to enable the development of accountability and provide some "measurement" to ensure hospitals are providing value for money.

Medical audit, on the other hand, is less straightforward. A controversial aspect is that the control of expenditure requires some control over doctors' clinical practice - a situation traditionally seen as impossible if clinical freedom is to be upheld. In order to bring about these changes, Management Information Systems (MIS) were created in order to collect and measure information about the organisation's activities and costs.

### *2.4 The Conservatives and welfare provision*

During the Conservative administrations (1979-1997), the welfare state began to be caricatured as "over-expanded, wasteful and incompetent... (it had) created a 'culture of dependency'" (Baldry 1990:4). During this time, increased use of means-tested social security benefits, for example for disability allowances, were introduced. However, social security expenditure increased rapidly, reaching £40 billion by the 1980s (Baldry 1990), largely as a by-product of the government's economic policies. The combination of monetary policies, meant to reduce escalating inflation, and policies meant to create a climate for enterprise and job creation were preferred over interventionist policies which would have led to the reduction of the soaring rates of unemployment. Even if the economic relationship between inflation and unemployment remained unclear, the Thatcher government was prepared to risk high levels of unemployment in order to bring inflation down.

The Conservative government passed forty Acts affecting local government during the 1980s. Some were meant to increase control over local government finance, others involved privatisation measures meant to stimulate market forces and to reduce public sector expenditure. Alongside these measures was a lowering of taxation levels in order to create incentives and changes in industrial relations law so as to curb union power, which was perceived as constraining the market.

Other reforms included a reduction in subsidies and increase in charges in areas such as health care. This era saw the beginnings of a significant growth in radical legislation affecting the NHS. The influential Griffith's report (1983), discussed below, brought a radically new outlook on NHS management and administration.

#### *2.4.1 The Griffiths Report*

The Griffiths Report in 1983 recommended (i) the creation of an NHS Management Board (now NHS Executive) (ii) the introduction of general managers at regional, district and unit levels removing the previous practice of joint responsibility between doctors, nurses and administrators and (iii) the provision of better quality and greater choice of services for patients within self governing hospitals.

The Griffiths Report was mostly, though not wholly implemented. Its spirit can be captured in Para 4 "One of the immediate observations from a business background is the lack of a clearly-defined general management function throughout the NHS. By general management we mean the responsibility drawn together in one person, at different levels of the organisation, for planning, implementation and control of performance" (Griffiths Report 1983:11). The report put an increasing emphasis on strategic as opposed to operational management. As a result, the distinctions between line, middle and senior managers became very explicit. Other reorientations of hospital management included non-executive members, such as "captains of industry", to bring a private sector focus to bear on the NHS.

Within some of the self-governing hospitals, implementation of quality measures have been 'used' top-down to enforce greater managerial controls and to legitimate change in working practices. Some of the features, which characterised this new emphasis on quality, were an increase in in-service monitoring and inspection. These included QA - quality assurance techniques and TQM - total quality management. These systems, which necessitate commitment at all levels of the organisation, encompass procedures, facilities, materials and staff activity aimed at achieving prescribed standards of quality. These changes also made clinicians and health practitioners responsible to their local corporate entity and its general manager. The wide acceptance and cohesiveness of the old model meant that attempted changes were often thwarted, sidetracked, or aborted at the regional, district and hospital levels.

The report introduced corporate business philosophy and techniques into the NHS. It stressed cost-effectiveness and managerial efficiency and proposed that decision-making, including decision-making by doctors, should be taken in the light of devolved budgets so that services and finance would be considered together (Paton 1999). In contrast, in the past, administrative and professional roles were largely distinct so that the former were not expected to intervene in clinical areas. The report suggested that, like the private sector, the NHS ought to concern itself with " levels of service, quality of product, meeting budgets, cost improvement, productivity,

motivating and rewarding staff, research and development, and the long term viability of the undertaking" (Griffiths Report 1983:10 Para 1).

The key debate surrounding the Griffiths report was whether a structure appropriate in the retail trade is also appropriate in the NHS. It has been argued that the handling of staff resources within a public service organisation where the service itself constitutes a large part of the 'product' needs an entirely different approach than the retail trade. The report's recommendation to "review procedures for appointments, dismissal, grievance and appeal (and to) identify any conditions of service which are not cost effective in management terms" (Para 9.5) is alien to the traditional NHS. There are a number of contradictions inherent in this report as it tries to acknowledge the NHS context yet hints very cautiously that considerable savings can be made from cutting down on staff resources.

> "... it is pointless to discuss manpower except in the context of the overall task and objectives of the NHS. Nevertheless, manpower does account for over 70% of total NHS costs, so better management of resources must mean better use of manpower" (Griffiths Report 1983:23 Para 35)

The need "to sharpen up the questioning of overhead costs" (Para 8.6) the insistence on cost improvement and effective use and management of all resources and the need for "real output measurement, against clearly stated management objectives and budgets" (Para 7) sums up the ethos of the Griffiths report.

Towards the end of the 1980s, the clinical autonomy of doctors was being questioned. These moves led easily to the introduction of consumer choice in healthcare – as well as in education and housing. The 'consumer choice' rhetoric was helpful in smoothing the introduction of further privatisation, decentralisation and corporatization - a formation which effectively separated regulatory functions from services delivery functions.

### *2.4.2 The Conservatives' Reforms*

Byrne (1997) puts forward the notion that the Conservatives' Reforms came in three phases. The first phase (1981-85) saw cuts in spending and an attempt to improve

basic management through the introduction of tools like the Financial Management Initiative in 1982. The original 'Rayner scrutinies' conducted by the Efficiency Unit were meant to encourage managers to outline clearer objectives relating to their devolved budgetary responsibility, provide for more and better management information, measure performance more accurately and define responsibilities more clearly (ibid.1997). Further, the increasing emphasis on privatisation initiatives was explained as a solution to problems such as personnel size and expenditure.

The second phase of Conservative reforms, (1987 – 1992) saw the introduction of quasi-markets in many areas of welfare. Internal markets were introduced in health and education systems. The NHS became once again the focus of further structural and organisational changes. By the end of the 1980s, the nature of citizenship began to change and the relationship between government and the citizen became distanced. For example, private pensions and private health insurance were encouraged through the enhancement of tax relief and the importance of the voluntary and informal sectors of welfare was highlighted.
During the third phase (1992-1997), attempts to reform state-society relations became more pronounced. This period saw the creation of devolved executive functions to semi-autonomous 'Next Steps' agencies – such as the Benefits Agency.

### *2.4.3 Working for Patients*

The introduction of the 'internal market' and the creation of a mixed economy of provision was an attempt at separating state finance from state provision ensuring the state had only a residual role as provider. This reform also encouraged competition and provision from independent agencies. The NHS and Community Care Act 1990, which was based on the review *Working for Patients* (DoH, 1989), relaunched an NHS with new self-governing hospitals (trusts) and a newly operational internal market on 1 April 1991.

Health Authorities in England and Wales and Health Boards in Scotland were allocated funds to purchase healthcare for their resident populations and were thus no longer responsible for provision of health care services. At the same time, hospitals

(and other providers) became autonomous 'trusts' – independent from local health authorities/boards. Trusts were expected to secure income from purchasers who contracted with a provider unit for specific services at an agreed cost. In addition, GP fund holding was introduced to enable GPs to purchase services on behalf of their patients.

Until the early 1990s, a common interpretative scheme, or set of values and norms, underpinned a set of organisational structures and systems in many UK hospitals. However, the new legislation led to the erosion of the general principle of uniform provision of services as competition between hospitals was introduced within a quasi-market (Kitchner 1998). In order to meet the requirements of the quasi market and new contract arrangements, all hospitals required to install comprehensive resource management and quality assurance systems. Although the quasi market was interpreted differently in different hospitals, it still 'imposed an information imperative.' When clinical directorates were introduced in the early nineties, commercial language was increasingly used on the wards and in clinical meetings (ibid.1998).

Paton (1999) argues that the NHS internal market not only did not function as a market, it did not even function like a quasi-market. One of the supposed benefits of this reform was that the money would follow the patient. This did not happen. Another problem was that transaction costs, especially in England and Wales[3], were high - a factor which may have been unforeseen. In addition, the purchaser/provider split created certain types of perverse behaviour and incentives. Crucially, however, most health authorities/boards went to local providers so that competitive markets involving a range of providers, both local and non-local, were largely absent.

### *2.4.4 Conservative welfare policies*

The top-down approach of the Conservative government has been criticised because its policy instruments were inappropriate. They lacked the support of the affected

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[3] In Scotland, this problem is less severe.

interest groups and relevant government agencies (Sabatier 1986). Similarly, Jackson (1992) is critical of what he describes as a state take-over. He argues that the conditions necessary for effective implementation of internal markets in the NHS were unrealistic owing to a number of factors such as (i) the scarcity of resources and (ii) that since policies are made and remade in the process of implementation, street level bureaucrats[4] were likely to take up adaptive strategies.

Despite the abandonment of Keynesian economics, total expenditure on social protection has increased since the mid 1980's. As pointed out earlier, one unintended consequence of the attempt to control inflation was a sharp increase in unemployment leading to a large increase in social security payments thus undermining the Government's objective of cutting public expenditure. According to Marsh and Rhodes (1992:177), expenditure in real terms on benefits for the unemployed increased by 46 per cent between 1978/79 and 1989/90. Apart from increased expenditure on income support, growing unemployment also led to greater expenditure on family credit and housing benefit. Clearly, the attempt to achieve one objective of economic policy, such as lower inflation, indirectly made it more difficult to achieve another objective, lower public expenditure.

At this time there were many signs that welfare policies were failing. Housing statistics, for example, illustrate the level of social distress experienced. Homelessness became increasingly acute and the number of households in arrears on their mortgages increased from 30,000 in 1983 to 130,000 in 1990 and repossessions of mortgaged properties grew from 5,000 in 1981 to an estimated 40,000 in 1991 (ibid.1992). At the same time, after the tenants' right-to-buy council property was introduced in 1980, owner-occupied housing in Britain increased from 55% in 1979 to 68% in 1990 (Baldry 1990). This was a period, which saw a dilution of left and right wing ideologies, encouraging traditional left wing voters, as well as politicians,

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[4] Street level bureaucrat's, from Lipsky's (1980) *Street Level Bureaucrats*, refers to public sector workers who have first hand dealings with members of the public. A discussion of the role and functions of street level bureaucrats is dealt with more fully in the chapter three.

to adopt right wing approaches and solutions. The demise of the old collectivist /socialist ethic was marked by the inauguration of ideological confusion.

The two Major governments between 1991-1997 continued on the same tracks as the earlier Conservative governments. However, the government-citizen approach now appeared to soften with the introduction of Citizen Charters in 1991 that allowed for published standards, complaints procedures and means for redress. Raadscheldon, et al. (1999:58) however point out that:

> "Citizen charters are hailed for giving citizens a tool to influence the degree of responsiveness of public services, but often create the impression of being used for administrative control purposes rather than for establishing an open democratic administration. The citizen charters, in fact, represent a very limited governmental response to the generally perceived need of revitalising the citizen as a member of civil society."

Citizen charters, imposed entirely from the top, were essentially 'glossed' with assumed notions of what is best for the citizen. Other initiatives included a new service-wide civil service code, the devolution of pay and grading responsibilities to departments and the introduction of investors in people.

The 1980s and 1990s saw more welfare and public services reform than in previous decades. These changes can be summed up as calls for efficiency, intense managerialism, privatisation, agencification, contracting out, regionalisation, decentralisation, deregulation and debureaucratisation. In brief, these changes heralded the triumph of economic rationalism. This new code became prevalent not only across departments domestically but across nation-states globally. And since capital controls had been abolished in the Thatcher years, the British economy became increasingly exposed in the most direct way to what is now often called globalisation. The impact of EC/NPM on health and welfare services, and specifically on the provision of maternity care will be discussed in the chapters that follow.

## *2.5 The New Labour governments 1997 –2003*

The manipulation of the welfare state by the previous Tory governments left a legacy which New Labour were either unwilling or unable to shift in the short or long term. By and large, Thatcherism's policies have been significantly and substantially accepted by New Labour. Accordingly, the debate has now largely shifted away from socialism vs. capitalism to a focus on how best to utilize the New Public Management (NPM) programme. Some writers, such as Ginsburg (1992), maintain that the British welfare state is now an odd mixture of socialist and liberal approaches. Others, such as Powell (1999), propose that the administration of welfare is underlined by a mixture of individualism and some collectivism and universalism, implying that there are not many traces of socialism left.

### *2.5.1 New Labour and the Third Way*

The Third Way was born as an alternative economic model, as an alleged solution to the tensions between entrepreneurial freedom and social cohesion. The Third Way can be described as an adaptation or an evolved version of Conservative policy. Powell (1999:74) describes it as " a poorly specified, pick and mix strategy, largely defined by what it is not" and that it most certainly is not "a coherent concept that can be applied more or less uniformly to different policy sectors." New Labour's Third Way model maintains functional flexibility in labour markets whilst protecting against the creation of inequalities through the minimum wage, union recognition, and the Social Chapter[5]. What marks out the New Labour approach from the Old left is that the latter is concerned with redistribution (even if it may be criticised for neglecting its production) whereas New Labour pledges to redistribute opportunities, rather than income, through education and training. However, like the New Right, New Labour accepts the centrality of market forces and the Party even altered clause four of its constitution to accommodate this fundamental change (ibid.1999). Like its Conservative predecessors, New Labour's economic policy "sustains a reserve army

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[5] The Agreement on Social Policy (Social Chapter) which is part of the Treaty on European Union which was signed in Maastricht in 1992.

of the permanently unemployed 'underclass' alongside perpetual insecurity among a periphery of part-time and short-term contract employees" (Taylor 1999: 95).

It may be said that the Third Way rejects social democracy while asserting community responsibility and opportunity yet without relying totally on a laissez-faire approach. The broad accomplishments of New Labour's Third Way have been minimum wage legislation backed up by education and training, increased spending on the NHS, reduction in school class sizes, a new childcare allowance, expansion of child care and the New Deal to help certain social groups back to work. Despite these adjustments however, the old emphasis on redistribution and equality have been clearly left out of the equation.

Third Way critics point out that in the aftermath of thirteen years of Conservative administration, fundamental issues and approaches concerning the needs of society, have not changed. Powell (1999) points out how, in essence, New Labour merely dresses itself in a new political language whilst leaving Tory strategies intact. The rhetoric is extensive: the term inequality has been replaced by inclusion/social cohesion and private by public/private and competition by cooperation/partnership. Further, a new political terminology such as stake holding, individual freedom, and the balancing of rights with responsibilities often hide the real problems faced by both citizens in general and citizens as workers in particular. New Labour rhetoric has focused on the centrality of work, the redefinition of citizenship as well as the redefinition of redistribution and equality.

Blairite social policies have been described as contradictory (ibid.1999). For example, the Social Exclusion Unit is meant to overcome the social exclusion which the government's economic policy itself sustains and generates so that the New Deal for unemployed youth and lone mothers is expected to work within a constrained labour market situation where a flexibilized[6] workforce is still being deployed as a solution to employers' funding constraints. Another paradox is the decentralisation

[6] A concept referring to the rise in the numbers working part time, fixed term contracts, free-lance, job sharing, seasonal work and other non-standard forms of work.

and devolution of central and local government that nonetheless utilises central controlling power to bring about certain results.

Can the Third Way be read as a new contract between citizen and state? The centrality and fiscal attraction of work underpinned by elements of compulsion confers a conditional citizenship[7], whilst the persistence of low benefits demonstrates a redefinition of Old labour's concepts of redistribution and equality. New Labour are making life on benefits less attractive – or even less eligible, shifting away from the idea of relative poverty back to the concept of subsistence income.

Other changes spell out a new contract between the state and public service personnel. For example, the insistence of central control and inspection as well as performance management in pursuit of official objectives, especially in health and education, are seen as both powerful and intrusive by both private and public sector employees. McElwee and Tyrie (2002) analysed 30 measures of private sector regulation, and 21 measures of public sector regulation or coercion making the point that such measures have grown steadily in recent years. Whilst the authors accept that the objectives of many are meritorious, the problem is that each represents greater state control. In the health service arena, further structural and organisational changes came in the form of a new Health Act in 1997.

### *2.5.2 New Labour and the New NHS*

New Labour's proposals in *The New NHS Modern Dependable* (1997) were designed to strengthen scrutiny of clinical performance and variations, and make increasing information on the costs and effects of treatment available. As outlined in the Scottish White Paper, *Designed to Care* (1997), which acknowledged that 'a market-style NHS has failed patients', health boards were to "be given power of approval" in relation to capital planning, property and senior medical posts, whilst the newly formed Primary Care and Acute Hospital Trusts, as separate legal bodies, were to

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[7] The relevant slogan being: *No Rights Without Responsibilities.*

have power over operational matters as well as over resource allocation including employment matters.

Central to the new NHS in England is the creation of the Commission for Health Improvement (CHI) which takes the form of an inspectorate making regular visits to hospitals and Trusts to check that each organisation has a system in place for ensuring quality. CHI also endorses the nomination of the senior professional in each primary care group to be responsible for clinical care. The publication of a list of reference costs for hospital treatments is also expected to improve monitoring of performance.

The Act in England also created the National Institute for Clinical Excellence (NICE), established on the first of April 1999, to assess evidence on cost effectiveness of existing and new treatments and produce clear guidelines for clinicians. These clinical audits bring doctors increasingly under the microscope, laying pressure on them to be more accountable and to perform better. Despite the wording of *The New NHS Modern Dependable* (1997) that implies greater power for professionals, representative bodies and the consumer, clinical governance[8] is effectively the source of increased centralised power and control. Powell (1999) observes that the use of purchasing agencies to prioritise and ration care means less power to patients and 'frontline' doctors and more power to politicians and managers and argues that "the so-called collaborative networks established in the New NHS (DoH, 1997) are in fact mandatory mechanisms for implementing central policy" (ibid.1999: 74).

As more direct government control continues, the new health care state can validly be categorised as an example of the 'new bureaucracy.' The NHS of old, the 'universal, comprehensive and egalitarian' service is increasingly becoming a complex and fragmented organisation led by 'command and control' government tactics. "By the end of 1998, the profusion of 'commands' by Department of Health

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[8] Clinical governance is meant to be main channel for improving the quality of patient care and developing the capacity to maintain high clinical standards.

circulars and executive letters was testing the patience of even the most willing senior managers" (ibid. 1999:73).

Other measures included the additional Patient Charters and private finance initiatives (PFI). The initial patient's charter launched in 1991 was followed in 1992 by the introduction of the Health Information Service (HIS) whereby each Regional Health Authority is required to establish an HIS, covering not merely health information but also public information about local health services, hospital waiting times, pharmacy opening times, dental care together with signposting to other agencies. As a direct follow up to what was originally a Conservative initiative, the NHS Executive pledged in 1998 to provide "access for NHS patients to accredited, independent, multimedia background information and advice about their condition ... lifestyle and health" (NHS Executive, 1998).

The Health Act 1999 ended the GP Fund Holding and instituted Primary Care Trusts (PCT), thereby nominally ending the internal market and imposing further quality control for the medical profession through the policy of clinical governance. Health Action Zones were created to incorporate partnerships between all sorts of different local agencies: the health service, local government, the voluntary sector, and other elements of the statutory sector.

Linked to the notion of a consumer-driven service is the role of the private sector to provide for additional resources. The Public Private Partnership (PPP) scheme (which followed the trend laid down by the Conservative's Private Finance Initiative) was endorsed by New Labour in the July 2000 when the Health Minister, Mr Milburn, declared his intention of transforming the NHS into a 'modern, 21st-century, consumer-focused service.' Amongst other proposals, the PPP scheme allows the private sector to provide the majority of funding for NHS capital expenditure. Currently, it is the dominant method for procuring public services involving capital spending in the NHS.

It may be said that New Labour inherited a welfare landscape not of its making. And rather than imposing any radical changes, the aims of the present government, as

outlined in various white papers, has been to accept some of the inherited NHS structures. The Health and Social Care (Community Health and Standards) bill which received royal assent in November 2003 hails yet another radical departure from the traditional NHS structure. This Act enables top performing, three-star trusts to apply for foundation status giving them greater freedom from Whitehall. Foundation hospitals will have the power to set their own levels of pay and conditions outside national agreements. Whilst flexibility to set local salary levels could undermine a national pay package, if not destabilise the national labour market, the new stakeholder councils are meant to give healthcare staff and the public more involvement in patient care. A new Commission for Healthcare Audit and Inspection (CHAI) is replacing CHI in order to scrutinise both the NHS and private healthcare sector, with a greater emphasis on policing than developmental support.

### *2.5.3 New Labour's economic policy*

New Labour is committed to keeping public finances under control, to reduce the public sector borrowing requirement by setting prescribed and steadily diminishing limits, to balance the current budget and then to use the surpluses to repay the national debt. The chancellor has also ceded operational responsibility for the control of interest rates to the Bank of England in a manner commensurate with price stability thus preventing the government from reducing deficit ratios via unanticipated inflation.

The main thrust of New Labour's economic policy is macroeconomic stability coupled with cautious supply-side measures to improve education and, in theory, long-term investment. Keynesian large-scale demand-side intervention, high taxation, high spending, redistribution, and collectivist social democracy are out and neo-liberal economics is in. Official documents show a convergence of Conservative and New Labour approaches in respect of low taxation, fiscal prudence, and the emphasis on private finance (Powell 1999). Taylor (1999:155) describes this convergence as a 'quantitative leap' in Labour's new economic policy illustrating how "new labour is more orthodox in strict neo-liberal terms than its conservative predecessor." With New Labour's dedication to the logic of the market and its

commitments to free trade, flexible labour markets, sound money and individual self-help, it seems to surpass the neo liberal economics of the Conservative era (Driver and Martell, 1998).

The political mood has shifted dramatically towards 'wise spending' as opposed to 'big spending'. This 'wise' spending is underlined by "fiscal austerity, public-sector wage restraint (and) the staged management of welfare retrenchment" (Taylor 1999:160) so that, despite Third Way assurances, New Labour are closely following the ideological precepts of neo liberal economics. Entrepreneurialism is encouraged with the state itself joining forces with private money to invest in joint ventures. The free market philosophy still reigns supreme and, in some respects, it can be argued that the frontiers of the state have been rolled back even further.

The moderation in spending and the retrenchment of the welfare state have been put down to the global impulse which imposes heightened capital mobility, labour market deregulation and accelerated speculation on the foreign exchange markets (Taylor 1999), thus leading to fiscal probity. The perceived constraints brought about by a global economy have been used as a justification for what Rhodes (1994) calls the 'hollowing of the state.' It also means that the globalisation gateway has provided an escape route for the state to become disinvolved from the social and psychological needs of citizens whilst providing for an indigenous human resource investment in a limited way. In some respects, the resuscitation of the welfare state seems to have been sacrificed on the altar of globalisation irrespective of which party governs.

### *2.6 Summary*

Since the presumed long period of stability between 1948 and 1973 and following the exposure of the global economy to the oil shock of 1973, the public sector has undergone many radical changes in its organisation and structure. Following the economic recession in the 1970s, Labour's retrenchment in public spending in 1975 paved the way for the harsher economic measures which were administered by the 1979 - 1997 Conservative governments.

From 1974, the NHS adopted elaborate new planning arrangements requiring each health board/authority to produce both strategic and operational plans. When the service was re-organised at this time, management responsibilities at the regional, area and district tiers were vested in multi-disciplinary teams consisting of an administrator, treasurer, and nurse and up to three doctors. Decision-making within those teams was by consensus which meant that each member had a power of veto. However, this structure was to change less than a decade later.

In general, the period 1979-82 saw a move towards decentralisation and the diminution of bureaucracy. After 1982, however, centralisation was recouped as the managerial ethic borrowed from the private sector became increasingly influential. The policies towards the NHS have not been continuous and consistent since 1979, for example, elements reversed in 1982 were modified again in 1988-89. Between 1989 and 1998, managed competition and internal markets became a key feature.

During the 1980s, Keynsianism, which seemed to go hand in hand with collective values, was abandoned in favour of stricter control of the money supply and a more comprehensive form of financial management. This rise of New Right neo-liberal economics was seen as a response to the "stagnant" and "unresponsive" public sector services and between 1979-1990, a reduction of public expenditure was accompanied by heavier reliance on market forces and enterprise. The government attacked waste, bureaucracy and over-government and priority was given to the reduction of taxation in order to improve incentives. Monetarism and the control of the money supply was accompanied by the privatisation of nationalised industries, the curtailment of trade union power and strong control over local government finance. The government encouraged private pensions and private health care and, in general, economic policy was increasingly geared to gain primacy over social policy.

The triumph of economic rationalism both domestically and globally in the 1980s and 1990s led to the failure of welfare policies. A steep rise in unemployment resulted, ironically, in a dramatic rise in social security expenditure. The renaissance of liberal economics in the 1980s has been closely linked to the rise of new managerialism and the impetus for managerial reform in the NHS during the 1980s

came very largely from central government's concerns with fiscal matters and, in particular, with balancing the books. A reduction in expenditure was imposed in order to suppress increasing resource demands resulting from demographic pressures, new technological developments, and rising hospitalisation rates.

Whilst doctors may have been ambivalent about the introduction of general management as outlined by the 1983 Griffiths Report, the market ideas contained in *Working for Patients* (1989) were received with hostility by the medical profession. This white paper proposed, inter alia, the setting up of self-governing Hospital Trusts, the separation of purchaser and provider, General Practitioner Fund Holding (GPFH) and the extension of medical audit.

Within the public services, these structural changes endorse a significant break with the past, ritualistically casting aside traditional public sector and professional values and replacing them with a diffuse set of management ideas imported from the private sector. Since the eighties governments have been involved in ad hoc reforms which are highly experimental – thus making continuous change a normal situation and the status quo the exception.

The use of purchasing agencies to prioritise and ration care has meant less power to patients, and 'frontline' doctors, and more power to politicians and managers. Large scale contracting out of services to the private sector was recommended by a Treasury study in the mid-1980s so that 'government' has been conceived as a series of contracts with competitive tendering and direct competition increasingly intermingling with the private sector.

The coming of New Labour in 1997 did not revive socialism and despite the Party's political 'discourse, ' it continued, if not strengthened, some of the now well-established managerial structures. The controversial Third Way which, inter alia, emphasises the centrality of work and the redefinition of citizenship, is underlined by a philosophy which largely endorses the earlier New Right tenets and, despite the window dressing, is far removed from the promotion of redistribution and equality.

Indeed, in some respects, New Labour economic policy has been described as more neo-liberal than that of the Conservatives.

The New NHS (1997) led to increased central power and control and by the end of 1998, the profusion of 'commands' by Department of Health circulars and executive letters were likely to have tested the patience of even the most willing senior managers. The NPM movement has spread widely and deeply in the public sector and within the NHS it has been criticised for reflecting accounting[9] rather than clinical or health enhancement criteria. The debate as to whether or not new managerialism has proved to be socially beneficial also centres on whether or not well-established social policy principles are genuinely responsible for the dependency culture. Within the NHS, principles such as comprehensiveness, equity, equality of access, and provision of services free at the point of use touch a keenly sensitive nerve which successive governments have recently and gradually attempted to anaesthetise.

[9] Chapter three includes a discussion on how the process of accountingization is sweeping through the public services.

# Chapter Three

## The theoretical framework: economic rationalism, new public management and social policy

> "Not everything that can be counted counts, and not everything that counts can be counted." Albert Einstein (1879-1955)

### *3.1 Introduction*

The previous chapter outlined the broad political and macro economic framework between 1973-2003 in the UK and its consequences on the welfare state, in particular, on health service provision. This chapter reviews the relevant theoretical work and bodies of literature which account for the way in which economic thinking has shaped social policies and, in particular, health policies. Linked to the philosophies underlying the neo liberal economic paradigm is economic rationalism which expresses itself in the form of the New Public Management (NPM) regime. This chapter discusses the way in which health services have been influenced, served, or disrupted by NPM. It also examines the devolution of budgets and clinical directorships and how the process of accountingization[1] is sweeping through the public services and looks at proposals which promote accounting and economic systems which give welfare more significance. Closely linked to these issues is the scope and domain of the medical profession's power and their resistance to changes imposed by central government. Another consideration is health care practitioners' inter-professional relations and the extent to which professional tribalism impacts on health service reform. Finally, the chapter focuses on policy implementation through

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1 This concept is clarified in section 3.7.2

the work of Lipsky (1980) and others. These theoretical issues form the backdrop to the fieldwork for this dissertation wherein policy implementation, maternity care budgets and the control and influence of obstetricians and midwives play an important part.

### *3.2 Economic rationalism and the submergence of social policy*

In what way is the administration of welfare different today from thirty years ago? Whilst the previous chapter took a broad look at the abundant administrative and organisational changes created by five Conservative and two New Labour governments which, during the last thirty years, have led to a gradual reversal of the collectivist ideals underlying welfare administration, this chapter gives a deeper analysis of the relationship between welfare and capital.

One of the fundamental values of Social Policy as a discipline and by extension the assumed values underlying social policy documents is 'social good'. Whatever difficulties there might be in trying to capture the full weight of this concept, it does suggest that economic activity must be subordinated to the societal goals which encompass it (Polanyi 1957). However, as Gorz (1989) observes, liberal theorists from Adam Smith to the present time have subordinated societal ends to economic rationality. Despite the increase in public spending at various times within distinct fields of welfare, the engine generating the economic system and which has become all pervading at the present time is economic rationalism which, according to Whitwell (1998), draws on neoclassical economic theory.

> "Its (economic rationalism) underlying 'vision' of the economy is the neoclassical vision. The unregulated capitalist economy is assumed to have an inherent tendency toward equilibrium: a situation in which demand and supply are in balance. The system is believed to be self-correcting."

Whilst according to Whitwell, economic rationalists are highly suspicious of government intervention, Gorz (1989), who sees economic rationality and capitalism as intertwined, explains that it would not be in the interest of capital to dismantle the

welfare state because capitalist development gives rise to collective needs which cannot be supplied by the market. Gorz (1989) argues that:

> "...it (the welfare state) is born of this very deployment, as a substitute for the societal and familial solidarity that the extension of commodity relations has dissolved, as a necessary preventing the market economy finishing up in a collective disaster."

For economic rationalists, greater efficiency is sacrosanct as is the need to maximise the efficacy of market forces. Since resources are to be allocated as efficiently as possible, the public sector needs to model itself wherever possible on the private. Such thinking has led to the development of certain sub-disciplines within Health Economics which, amongst other things, use rigid quantitative tools to measure essentially qualitative features. Economic calculation is not always possible or rational on a social, psychological, or medical scale. Certain activities, such as the quality of care or assistance given by public service personnel, are resistant to the economic imperative. The quality factor inherent in all services can leave an element of uncertainty in both social and economic outcomes. Rigid calculation constricts the non-tangible aspects of the public services into becoming a by-product of economic measurement so that the social, ethical, and political possibilities outlined in social policy prescriptions must bend to the calculative pulse.

Gorz (1989:200) criticises economic rationality as a self-serving philosophy which bypasses declared social needs, arguing that the roots of economic rationality are narrow and limited to counting and calculating.

> "... a mathematical formalization of thinking which ... *insulates it against any possibility of reflexive self-examination* and against the certainties of lived experience."

In particular, the blatant domination of economistic thinking over the wider 'social good' results in a diminished democratic citizenship especially for those members of society who are economically vulnerable.

Whether past and present policies emerge from extreme left or extreme right or so-called middle way or Third Way philosophies, the political engine has, in each case,

been driven by an economic rationality, a system which despite its logic is unable to apprehend or satisfy collective and unsystematic social needs. No British government in recent history has experimented with the possibility of subsuming monetarization, rationalization and technicization into a larger societal framework which acknowledges the lifeworld - a concept described by Gorz as "the organised world, which is informed and interpreted by our knowledge, our habits, our customary relations, our familiar techniques." Rather, the lifeworld has come increasingly under fire. Habermas' thesis points out how the permanence and coherence of the lifeworld can be threatened by the colonisation of economic and political agencies. Such crisis upsets the life experiences, beliefs, and demands of the lifeworld leading to systems getting out of hand and original values turning on their head. Such a situation is easily illustrated in the case study which forms part of this enquiry. It demonstrates how excessive economic, political, and medical intrusions in the maternity care setting (the lifeworld) results in obstetric pathologies becoming the norm. Economic rationalism is saturating not only the lifeworld of the various social and public settings it has come to dominate, but, according to Pusey (1991:10), everything that policy decision makers do in their "fateful role as brokers and authors of a nation's destiny." According to Pusey's diagnosis, the public welfare ethic has become increasingly lost in a mist of economic rationalism which has become the new civic cult capable of being 'activated' globally because the social context is unimportant.

Yet, certain aspects of the role of the health care professional can be described as self-directed and in essence resistant to economicization. Self-directed action may be largely inevitable and in this context risks both desirable and undesirable consequences. The 'quantification of the qualitative' and the 'equalisation of what is not equal' are clearly inoperable tasks. Yet, this approach is pandemic in some branches of health economics where economic modelling is seen as "the ultimate 'intellectual' resource for reducing complexity" as well as uncertainty "to the purely formal and self-referential logic of money." Pusey (1991:201). Calculability does have its place in social and political planning. However, as critics point out, strategies based on economic cum managerialist calculations are in danger of being

at odds with the real interests of the citizens and constituencies whom they are supposed to serve.

The question is whether the materialistic assumptions upon which economic rationalism is built might be hindering its potential service to society.

### *3.3 New Public Management – the rationale*

Measures to remodel state services in accordance to the presumed structures and processes of private enterprises were introduced in 1980s and 1990s to redress the deficiencies of bureau-professionalism[2] which were perceived by New Right as inert, unresponsive, union dominated and governed by producer interests. In particular, New Right analysts and user groups have challenged NHS efficiency and the notion of disinterested, consumer-based provision.

The Thatcher administration, seeing public sector trade unions as greedy and overbearing and who put their needs first over the community (Mclaughlin et al. 2002), was encouraged to consider privatisation and marketisation of public services leading to the conception of the 'enabling' state. In response to "bloated, wasteful, over-bureaucratic and underperforming" public services (ibid. 2002), the mechanisms of the new managerialism were to provide greater choice, to ensure quality and achieve value through competition and marketisation. Additionally, the extension of the range of providers were meant to promote market-type conditions whilst the setting of standards were meant to ensure accountability. Quality and value were to be enhanced through the provision of information and independent inspection as well as the provision of incentives for performance through competition.

In Britain, New Right thinkers and politicians poured scorn on those who still held on to the belief that social problems would be solved by improved government

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[2] Bureaucrats are publicly accountable and provide standardised provision – professionals assess user-needs and dispense appropriate treatment according to their expertise (McLaughlin et al 2002).

planning. Bureaucracy seen as "rule bound, inward looking, compliance centred and ossified", contrasted with a view of management as "innovative, externally oriented, performance centred and dynamic" (Clarke and Newman 1997). Waste was seen as clearly linked to over-government. The intention was to curb 'provider power' through competitive markets. The business management ethic which is alleged to be "customer centred, transparent, results oriented and market tested" was to replace the "paternalist, mystique ridden, standard oriented and self-regulating" professionalism and to shift the "public indifference and unresponsiveness", if not "downright arrogance", of public servants (Hood 1991: 65 & 40).

Ironically, criticisms were also centred on politicians themselves. If politicians are "dogmatic, interfering and unstable," managers, on the other hand, are "pragmatic, enabling and strategic" Hood (1991:65). There was a perceived need to increase the productivity of public services, to maintain, if not increase, their quality while total resources devoted to them were to be held down. Government was seen as too expensive, hence the popularity of management solutions to what were previously conceived of as political problems (Hood 1991).

A new approach to public services came about in response to these apparent failures which were used as supporting evidence. According to Hood (1991), the theoretical sources of NPM were monetarism, public-choice theory and libertarian philosophy, a "body of scholarship and polemic ... transformed into an apparently simple (but radical) programme for addressing the major perceived contemporary problems" (Hood 1991: 43).

McLaughlin et al. (2002:4) explain that managerialism gained its legitimacy because its ideologies and institutions provide a coherent field that underpins these shifts. Public services have become " a set of values, a code of behaviours and forms of practice" which have became institutionalised. Thus, new managerialism is remaking the culture and ideology of the British Welfare State (Clarke and Newman 1997)

### *3.3.1 New welfare and new public management*

NPM can be described as an ideology which upholds the superiority of a particular way of co-ordinating delivery of welfare services. It comprises a body of knowledge, techniques and set of prescriptions about the most effective and efficient way to run state services. Its ideology is borrowed from commercially derived practices, thus adopting the terminology and culture of private business. Pollitt (1993) describes its origins as being big business and the military, whilst Barzelay (2002) suggests that NPM acquired its policy proposals from the doctrinal claims of new institutional economics (NIE) in particular: i. public choice theory; ii. transaction cost economics; and iii. economic theory of agency. For Aucoin (1990), NPM is about organisation design with its intellectual foundation coming from a blend of i. normative public administration theory; ii. new institutional economics; and iii management studies. Other NPM analysts such as Osborne and Mclaughlin (2002) list eight doctrines of NPM.

- Entrepreneurial management replacing bureaucratic public administration
- Explicit standards and measurements of performance
- Emphasis on output controls
- The disaggregation and decentralisation of provision of public services
- Shift to the promotion of competition in the provisions of public services
- Stress on private sector styles of management and their superiority
- Promotion of discipline and parsimony in resource allocation
- Separation of political decision-making from the direct management of public Services.

Management is an activity concerned with directing flows of resources so as to achieve clearly defined economic objectives such as 'output' and 'value for money'. Managerialism is concerned with results, performance, and outcomes (Pollitt 1993). According to the classical school of managerialism, all organisations are systems with inputs (such as resources and demands) and outputs (such as decisions, products and services). However, the claims to a detached, rational, and 'scientific' ethos are

highly dubious for it is certain political values which form the substance of management thinking. For example, NPM puts an emphasis on control and finance and less on planning and established organisational structures (Pollitt 1993). This fundamental political option is hidden below managerialist terminologies such as devolved budgeting, targets, action plans, performance indicators, staff appraisal schemes, merit pay, activity costing, cost improvement and income generation opportunities.

Has NPM supplanted traditional forms of public administration? Hunter (2002) describes it as a move away from the traditional public service ethic. The impact of NPM on public services has been very uneven both nationally and globally and is seen as an evolving phenomenon (McLaughlin et al. 2002). Therefore, the nature of NPM remains a subject of intense controversy. For example, in some areas of public administration, guidelines emerging from the doctrines of NPM may have had little effect whilst in others complex forms of accommodation may have emerged as a result. Pollitt (1993) notes the international spread of this new brand of managerialism despite differences in political culture and institutions and Hood (1991) describes it as "portable and diffuse" and seen as solving the managerial 'ills' from Denmark to New Zealand and in different organisational contexts, policy fields, and levels of government, giving it a claim to universality.

Is NPM, therefore, a politically neutral and all-purpose instrument for realising whatever goals elected representatives might set? Not so, according to Pollitt (1993), who sees it as an ideology with concrete and immediate consequences.

> "Managerialism is a set of beliefs and practices, at the core of which burns the seldom-tested assumption that better management will prove an effective solvent for a wide range of economic and social ills."

The confluence of managerialism and welfarism has brought about various levels of displacement of the traditional administrative mechanisms and a consequential shift in the power and nature of professional work. The management of people, resources, and programmes have replaced the administration of activities, procedures, and

regulations. It has also meant the dissolution of 'bureaucratic' rigidities in the employment relationship, including the reduction of professional autonomy and the weakening of unions. Thus, the professional contribution of many public servants has been devalued. Yet, the expectation that public officials who are paid out of local rates or taxation should act with fairness, responsiveness, honesty, and accountability lingers on.

Ultimately, the financial cutbacks, which accompanied the many reforms, have diminished the distinctive status of citizenship in public service transactions. Benefits and services are allocated according to rational principles as opposed to a historical/incrementalist criterion and professional assessment of 'need' is replaced by one based on demand within a market framework where clients become customers within a fragmented market orientation. In many areas of public welfare, 'better management' is experienced by many public servants as tighter control rather than a form of enhancement (Pollitt 1993).

### *3.3.2 Some of the consequences of New Public Management*

NPM can be understood as a response to a crisis in welfare administration as well as a crisis in economics. But has it proved to be the right formula to reduce welfare dependency? Critics such as Pollitt (1993) maintain that NPM has been implemented to solve economic rather than social problems. Apart from NPM's inability to deliver enhanced welfare for the citizen, Ferlie et al. (1996:195) maintain that its top-down, or externally driven or power driven change strategies, are less effective or sustainable than the previous system of public administration, explaining that " the lack of robust models of accountability in the public services now gives rise to considerable concern, and this may represent the Achilles' heel of the NPM."

The breaking up of longstanding rules, conventions and relationships and the renegotiation of new ones have been boldly and dramatically restructured through a

series of statutes[3] signifying a departure from earlier policy (Meek 1998). This 'unlearning' of past behaviour and the learning of new behaviour has led to the dissolution of the old culture and the birth of a new one borrowed from private enterprise, where notion of 'need' and 'justice' are non-existent. As Pollitt et al. (1988) and Hood (1991) point out, the nature of tasks in the private and public sectors are fundamentally different.

Hood (1991:10) describes NPM in the work environment as a vehicle for particularistic advantage, "a self-serving movement designed to promote the career interests of an elite group of 'new managerialists' rather than the mass of public service customers or low level staff." Pusey (1991:183) puts it more strongly, suggesting that this can sometimes mean the speeding up of lateral job mobility between different departments and sections, and the imposition of heavy work pressures which are unfortunately selectively experienced by some but not by others: "...careers (are) redefined (symbolically if not always personally for the individuals concerned) as means to ends that are set by an external market and valued in dollars by private and particular interests."

The new public management is characterised by a series of organisational tensions. For example, contrasting pressures to decentralisation and autonomy and to centralisation and control are reflected in the way that staff are treated and managed. Pressures for commitment to organisational values and culture, combined with more differentiated personnel systems, have resulted in harsher working conditions for many (Walsh 1995).

Overall, new managerialism has meant a slow down in job promotion for some, and sudden and steep promotion for others, irrespective of the overall impact on services. In addition, in some areas of welfare, a consensus model was replaced with one based on conflict and low trust relationships (Hunter 2002). According to Fox (1974) trust in the work environment has at least three components: i. the opportunity to

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[3] Education Reform Act 1988; Housing Act 1988; Local Government Finance Act 1988 and The National Health Service and Community Care Act 1990.

share (or have similar) ends and values; ii. the ability to offer support without expecting an immediate return; and iii. open and free communication. The injection of the various elements of NPM, not least the incongruous unleashing of the entrepreneurial style within public servants' work environment, has jeopardized all three ingredients.

Hood (1991) suggests that NPM is 'all hype and no substance' and that aggrandised managerialism has damaged the public services and has not effectively delivered on its central claim to lower costs per (constant) unit of service. The language of NPM is hyped up to convince that its implementation is meant to bring about both social and economic benefits. Yet, the management and control of limited resources is one of its overriding features. Echoing some of Hoods concerns, Ferlie et al. (1996:196) explain that in some models of NPM "improved performance matters more than process and excess concern for accountability is seen as getting in the way of results." Harrison et al. (1992:15) express the limitations of the new managerialist system by pointing to the issues of honesty: "If NPM is a design for putting frugality at centre stage, it may at the limit be less capable of ensuring honesty and reliance on public administration".

Many of the negative observations made about NPM stem from a premise that the previous system of social administration was more just. However, before the appearance of NPM, welfare and public services were not above criticism and were far from functioning optimally. Nevertheless, in comparison to the contemporary managerialist systems, the administrative and organisational drivers were likely to be underlined by a fair degree of equity and democracy. By the mid eighties, the drivers were changed to economy, efficiency, and effectiveness. Hood (1991) poses the question as to whether NPM is a correction for the moral bankruptcy of 'old' public management or whether it is "a gratuitous and philistine destruction of more than a century's work in developing a distinctive public service ethic and culture." Ultimately, both suggestions may reflect some veracity reflecting the old and the new systems.

This tilt in the balance of power can be described as resulting from a system which is accountable to 'accountability' rather than the community it is meant to serve. Ferlie at al (1996:210) suggest that the rhetoric of the NHS Management Executive (1992), which seeks to develop adventurous strategies for acquiring information and demonstrating downwards accountability, does not bear up in reality, nor does there appear to be any formal mechanism to ensure the accountability of NHS trusts downwards to the community.

> "We surfaced more accounts of upward accountability, perhaps reflecting the move to a more tightly managed and vertically integrated NHS or alternatively the arrival of more hierarchically minded executive directors on the board. This shift runs counter to the recent rhetoric of increased devolution and decentralisation" (Ferlie et al. 1996:216).

With new managerialism user involvement may be sacrificed at moments of crisis and tension owing to contradictory pressures on purchasing organisations. In addition, "consumerist ideas may fail to reduce the disparity of power between the users and providers of public services" (Ferlie et al. 1996:214). In reality, issues of quality and customer empowerment have produced new sites of conflict where "improvement of quality (was) seen both as a justification for and an outcome of radical organisational change" (Kirkpatrick and Martinez Lucio 1995:7). Although the new enterprise culture has colonised the public sector, consumer relations have been imposed within a centrally managed market which has resulted in increased control over users' lives (Thompson 1995).

According to Clarke and Newman (1997), the instabilities brought about by the new managerial state instigated the demise of the social democratic state. Although NPM is depicted as both universal and politically neutral it can, ultimately, be an instrument for realising whatever goals elected representatives might set. Hood (1991) sets out counter-claims to NPM's alleged adaptability to all public service settings. For example, not all users or customers are predisposed to exercising choice because the raison d'etre of some organisations, such as social care and criminal justice, is such that consumption is *imposed* on service users. The claimed advantages of NPM, such as increases in value for money and the sharpening of incentive structures, would seem to be heavily outweighed by numerous

disadvantages, such as high levels of uncertainty, consumer risk aversion and producer opportunism (Meek 1998).

### *3.4 New managerialism and the NHS*

Hunter (2000) suggests that the British health service, which employs about one million people, is a national service but not a unitary organisation. The recent flood of new initiatives into the NHS has meant increased pressure on managers to deliver on waiting list targets and on tight financial targets. Whilst not all initiatives stem from the business ethic, performance management is still the government's preferred style and dominates all NHS provision.

Managerialism in the NHS means, amongst other things, a demand to maintain throughput and numbers, output targets, efficiency measures and the balancing of books. Managers are expected to be uncompromising in questioning the commitment of doctors through their working practices and to account for their time. This intensive intrusion has been criticised as it detracts from the whole point of providing health care effectively (Hunter 2000). Although the new public management was launched to improve public sector performance according to a number of analysts, (Raadscheldon 1999; Pollitt 1993; Pusey 1991; Clarke and Newman 1997) the notion of 'performance' may have taken precedence over the quality of services delivered.

Pollitt (1993:185) questions whether the NHS has moved from a view of the service as 'health care totally free at point of service' to some more bounded definition of what can be available; and expresses concern over what will become of the professional service providers: "will they be effectively 'deskilled', deprived of most of their discretion and made slaves of the latest public fad or fashion?" In a similar vein, Hunter (2000:74) explains that since government resources are accompanied by stringent conditions concerning how they are to be used, "local priorities are sidelined as the centre focus on what it deems to be a priority." Hunter (2000:75) calls the endless stream of targets, performance indicators, inspection arrangements, and incentive schemes "unworkable and dysfunctional," asserting that abundant evidence indicates their deficiencies.

### *3.4.1 Griffths and health service management*

The 1983 Griffiths Report represents the template for new public management in Britain's NHS (Pollitt 1993). It was the necessary foundation upon which the later reforms, Working for Patients; and NHS and Community Care Act 1990, were to be built. Nevertheless, it was a series of government guidelines, such as the Raynor Scrutinies to scrutinize particular areas of expenditure; review of NHS audit; competitive tendering; Value for Money and the deployment of firms of chartered accountants, which led up to the Report. Griffiths represents a break with past practices in at least two ways: i the creation of general manager posts; and ii the loss of professional influence generally as managers were effectively given the right to override doctors' objections. Harrison et al. (1992:94) contend, "general managers can therefore be seen as, in principle, the antithesis of the 1974 system of consensus team decision-making."

The Report tends to portray managers as technicians who apply principles from management 'science' to the problems of his/her organisation. Such 'science' does not address matters of priority, for example how to spend resources; rather, it is loaded with a rationality which hides "profoundly political questions of priority and value" (Harrison et al. 1992:69). Management, itself, is not subject to microeconomic analysis. Rather, "*investment* in better judgement, better systems and better information technology is treated as an act of faith" (ibid xi) and, in a health care setting, so is investment in medical technologies. Harrison et al. (1992:72) argue, "financial stringency has cast a shadow over the Griffiths vision of a general manager-led cultural revolution." The need for care, assistance, or help, therefore, has non-market place elements in it. Since the medical market does not follow the classic rules of supply and demand, productivity is impossible to measure and therefore impossible to maximise (Gorz 1989). Not only do different patients make different demands, but also the number of patients seen is not necessarily an indicator of efficiency.

### *3.5 Auditing, accountingization and social policy*

According to Hood (1995), progressive public administration (PPA) has been replaced by NPM. Whilst the former is described as 'democratically accountable', has elaborate procedural rules and is sharply distinct from the private sector, the latter is largely focused on results through different styles of auditing and accountingization[4].

> "The basis of NPM lay in reversing the two cardinal doctrines of PPA; that is, lessening or removing differences between the public and the private sector and shifting the emphasis from process accountability towards a greater element of accountability in terms of results. Accounting was to be a key element in this new conception of accountability, since it reflected high trust in the market and private business methods ... and low trust in public servants and professionals ... whose activities therefore needed to be more closely costed and evaluated by accounting techniques" (Hood 1995:94).

NPM, therefore, gave birth to a generation of "econocrats" and "accountocrats" in high public office. Private firms of chartered accountants were hired to study the possibility of cash limiting and to audit the accounts of health authorities.

#### *3.5.1 Auditing*

The recent upsurge in auditing has been described as a new form of 'image management' whose alleged neutrality is questionable (Power 1997). Its increased use in public sector settings announces a cultural shift away from social science to managerial epistemologies. Rigorous conformity to auditing processes is liable to constrain the definition of public service quality and performance as it provides:

> "... deluded visions of control and transparency which satisfy the self image of managers, regulators and politicians but which are neither as effective nor as neutral as commonly imagined" (ibid:142).

The public service contexts in which audits are demanded can influence the environment in which they operate so that audits can go beyond problems of

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4 This concept is clarified in section 3.7.2

accountability and their deployment can bring about both undesirable and unintended consequences. The power of auditing can prove to be counterproductive, such as when "games are played round an 'indicator' culture where auditable performance is an end in itself and real long term planning is impossible" (ibid:121); or, for example, when auditees develop exploitative strategies to cope with inspections to ensure they are perceived as complying with performance measurement systems.

The primary objective of auditing is to verify financial 'realities'. Yet, audits call for considerable discretion in their implementation. For example, when auditing for 'effectiveness' in health service settings, standards may be borrowed from different bodies of knowledge. Auditing is forced into a compromise between programmatic demands for control and the realities of operationalizing it. Although a seemingly innocent pragmatic exercise, auditing can hide a number of political aims. Whilst it can wield a great deal of administrative control, it does not necessarily contribute to transparency and democracy, nor does it necessarily provide a basis for informed dialogue and discussion about the cost and quality of services being audited. Power points out how the audit society has opened a gulf "between poorly rewarded 'doing' and highly rewarded 'observing'" and how during the 1980s and early 1990s, structural changes in organisational governance led to auditing acquiring "an institutional momentum which insulated it from systemic inquiry" (Power 1997:142 and 147).

### *3.5.2 Accounting for social policies*

The 1980s saw a shift towards accountingization – the diffusion, growing density and complexity of accounting knowledge resulting in increased refinements of costing and budgeting systems and the emergence of specialisms within the accounting profession (Power and Laughlin 1992). Accounting is a necessary tool for keeping an effective record of monetary transactions. However, although the figures may be highly visible, their meaning is often opaque (Klein, Day and Redmayne 1996). The functions of accounting are understood to be a formal set of procedures whose techniques are neutral and incontestable, yet can be used as a powerful tool to distort or enable communication and representation.

> "Financial statements represent the pinnacle of accounting colonization by providing a dominant representation of an organization which eclipses other possibilities" (Power and Laughlin 1992:131).

Ultimately, accounting is an elaborate form of economic calculation which can potentially be a controlling factor on modern public services and which has a capacity to liberate or oppress the key values stressed by various social policies.

How should public sector accounting be conceived? What records ought to be kept? How are they to be used? What should be costed? What should be measured? These are important questions if the masking of what really takes place inside a hospital unit or in any other public welfare organisation is to be avoided. Often, an economically grounded concept such as 'efficiency' can repel critical inspection and "exhaust the space of possible discourse" (Power and Laughlin 1992:130). Sometimes accounting becomes a symbolic resource for the organisation as a whole as opposed to a functional resource for decision-making. Power and Laughlin (1992:119) also add, "accounting information can also serve to rationalise and justify decisions *ex post* or can be used as 'ammunition' in organisational politics." The authors reassure, however, that whether or not accounting can be regarded as enabling and facilitative or merely coercive and distorting is an open empirical question.

Accountingization may eclipse broader questions of accountability so that *knowledge* accumulated through social science research can easily be overridden by accounting *information* which sounds true. Such information has a capacity to mobilize a particular political agenda instead of representing the needs or requirements situated within public service organisations. Accounting systems which treat human subjects as 'calculable' and 'calculating' individuals could reap unexpected behavioural consequences in local organisational contexts. Neo-Marxist perspectives argue that some accounting techniques, which are bound up with economic rationalism, can be profoundly dysfunctional for labour. Even when there is clearly no complicity between traditional accounting and political agendas, the treatment of labour simply as "one cost 'above the line' amongst others" encourages exploitation (Power and Laughlin 1992:120).

Labour-conscious accounting runs parallel to other forms of welfare engendering systems such as health and environmentally conscious accounting. Some 'rational' economic actions operate their own limited imperatives at the expense of others and can produce dire consequences for social and global welfare.

> "Increasing accounting-based specialization ... is more generally the monopolization of modes of reason. (It) propagates an economically based discourse which can control the public definitions of social and organisational reality and hence the 'problems' and 'needs' of those domains" (Power and Laughlin 1992:130).

How public sector accounting should be conceived, what records ought to be kept, how they are to be used, and what should be costed and measured are the keys to social transformation. The rigours of accounting techniques and procedures can be attuned to uphold the principles of social welfare so that welfare becomes the defining lens through which holistic economics take into account *who* produces, *who* allocates and *who* consumes. The practice of welfare conscious accounting, therefore, could hold the solution to a number of social problems. The need to recover the social and subjective dimensions of accountability means that accounting systems could take into consideration optimal outcomes, and to accurately distinguish between different forms of expenditure: those that result in welfare gain and those that carry potential welfare loss. Whilst the technical neutrality of accounting is illusory, unlimited aspiration and reflexive awareness can be "achieved with the help of a broader based transformation of economic reason and calculation" (Power and Laughlin 1992:132).

Accounting can be described as a vehicle of economic reason in practice and those who critique that there is no independent economic reality *per se*, tend to see accounting as a representational practice which is implicated in *creating* that economic 'reality'. Despite the continuing rhetoric to the contrary, the problem of representation suggests that there is no single way to account for economic reality so that "accounting ... creates the economic facts that it purports to represent" (Power and Laughlin (1992:117).

### *3.6 Social policy and professional values, beliefs and culture*

In the past, public services were characterised by fixed salaries, rules of procedures, a division between the public and private sectors, permanence of tenure and restraints on the power of line management. Within the health service, doctors and nurses were expected to treat patients in accordance with their training, a tradition which survived more or less intact until the mid 1980's. The state was viewed, by Fabians at least, as a neutral power standing above society. Government was the engine of social progress and its purpose was to ensure that such progress was ordered and rational in contrast with the speculative unpredictability of the marketplace. "This view of the neutrality of the state coincided with the neutrality of professionalism (or, more accurately, the neutrality proclaimed in professional ideologies)" (McLaughlin et al. 2002:7). The medical profession's authority was bolstered by the view that they are objective, scientific, and neutral and their expanding influence resulted in an increase in the number of hospitals, the growth of specalisms and eventually the need to centralise training. Accordingly, health care expenditure grew swiftly as medical schools expanded.

Today, the extent of the authority and status of the medical profession has become a contested issue as governments expect them to justify and account for their actions in ways unimaginable a couple of decades ago. Additionally, their credibility is being questioned by service users who demand greater openness, tolerance and responsiveness to their expectations (Ferlie 1996). The role of doctors vis a vis their patients has been increasingly exposed to critical scrutiny in recent years.

> "While the relationship has traditionally been marked by a deferential and uncritical attitude on the part of the patient, service users have begun to express greater concern over issues like variability in clinical practice, excessive waiting times for treatment and uncommunicative personal styles" (Harrison et al.1992:102).

Not all of these issues can be put down to inadequate resources as mounting research evidence suggests that the causes may be linked to the documented fact that medical practices and interventions are not always as successful as is assumed or claimed. According to Illich (1977) and Illich et al.(1977), medicine is by its very nature

exploitative and meddlesome and sometimes medical interventions cause more harm than good. It was the questioning of medical expertise and the profession's claims that their interests are one with those of the wider community that emboldened the then Secretary of State for Health "to play on this theme in the immediate aftermath of WfP[5]" (Harrison et al.1992).

> "Ministers had effectively signalled that cost effectiveness concerns dictated that professional practice could no longer be regarded as sacrosanct from external scrutiny" (Wistow 1992:108).

Yet, doctors are adept at redirecting or neutralising attempts by governments and managers to control them. Medical audit, for example, "remains under the control of doctors despite its potential for giving managers a weapon to control ineffective doctors" (Hunter 1994:19). Overall, the profession's dominance over patients still holds despite any loss of power and/or autonomy owing to increased state intervention. Ferlie et al. (1996) explain that state intervention has not de-professionalised doctors but has simply resulted in professional adaptation. In particular, during periods of organisational and structural change, the medical profession is more likely to assert their control, status, and boundaries at both individual and collective levels.

The state governance of health care would seem to conjure up an impression of hospitals as machines and clinicians as components and patients as raw materials which will respond to the health care process in a predictable and uniform way. Such a view may be resented by both service users and health care practitioners who perceive state interference as a 'secular' intrusion into the 'sacred' space of medical autonomy (Laughlin et al.1992). Although the individual doctor's autonomy is becoming increasingly limited, professional discretion is more extensive in the NHS than in other areas of the welfare state (Hunter 1994).

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5 WfP: Working for Patients. (Department of Health (1989) Working for Patients: The NHS Review Cm 555 London: HMSO)

The medical profession claims a unique cultural status and possesses distinct resources such as its expertise, its position as a rich pressure group, as well as the public perception of it. It is perceived as " a responsible professional body rather than ... a grasping, self-interested trade union" (Harrison et al. 1992). The profession's position and high esteem in the social structure, the doctors' high levels of discretion and the uncertainties stemming from the nature of their work do not combine very well with resource limitation and external intrusion. These issues form the basis for their drive to fight off and reject unwanted changes.

Ferlie et al. (1996:169) distinguish between three main forms of medical autonomy.

> "Political autonomy, the right of the profession to make policy decisions as the legitimate experts; economic autonomy, the right of the profession to determine remuneration; and technical autonomy, the right of the profession to set its own standards and control performance."

By and large, the professions believe that high standards of care are dependent on the 'level of resource availability' - a matter that is not seen as the responsibility of the doctor and that there is a level of resource availability below which doctors are not able to provide reasonable standards of care. Yet, as Harrison et al. (1992) point out, there are wide variations between hospital doctors in the resources used in treatment.

The power of the medical profession lies largely in the way it has secured control over its knowledge base. Larkin (1983:4) explains that the key to securing "occupational imperialism ... involves a definition of what illness is and how it is to be treated" though, as Ferlie (1996:170) points out the identifiable body of medical knowledge is "culturally defined and bounded." From this perspective, state intrusion is resented, as Degeling et al. (2001a: 65) note:

> "A critical aspect of the power relations within health care systems is that medicine has distinct interests and concerns, which often differ from the purposes, priorities and tasks set out in policy statements and plans. Reform initiatives which cut across the profession's interests and understanding of what is 'natural' and 'necessary' will be avoided, resisted or opposed" (Degeling 2001a: 65).

Following the Griffiths report in 1983, doctors were pressurised into being more cost conscious and consultants were to become *resource managers*, responsible for the costs of running their particular clinics. The profession's control of "diagnosis, treatment and care of patients" is described by Dent (1991:69) as an institutional function, whereas the management arrangements as prescribed by the state are an organisational function which "impinge upon the doctors' professional autonomy." As Harrison et al. (1992:148) aptly put it, "Managers continue to be seen as agents of the government in the way that doctors and nurses and other service-providers are not."

The values, beliefs and culture of the medical profession which have been weaved and consolidated over the years have become even more accentuated at the medicine-management interface. Economic rationality as expressed in financial management and budgeting and associated with the contractual accountability model goes against the grain of professional rationality (Clarke and Newman 1997). This view echoes an earlier one by Harrison et al. (1992:143) who state that recommendations constitute "a significant incursion into the medical domain." Aggregately, doctors comprise a dominant professional group able to exercise considerable power, but the micro-power of individual doctors is trimmed down as "core medical activities of diagnosis, admission, prescribing therapies and deciding on discharges" (ibid 1992:143) are scrutinised externally.

*3.6.1 The impact of management on professional tribalism*

The medical profession's beliefs, values and culture would seem to be more deeply ingrained than the values of economic rationalism, but professional tribalism adds one further complication. Hunter suggests that the government does not appreciate the different sub-cultures operating within the health services.

> "The management model in vogue is seriously flawed because it misunderstands the nature of management in a complex service that is in effect dominated by a powerful professional group. It does violence to the different value sets and cultures that exist among the various professional groups, or tribes, that inhabit the NHS" (Hunter 2000:75).

Although the inclusion of lay and medical managers within the core of the hospital environment has, in some cases, dramatically changed the power relations, NHS subcultures and tribalism remain (Harrison et al. 1992). However, disagreements amongst the medical profession do exist and moves to implement managerialist systems have exploited this weakness (Hunter 2002).

Health care analysts have tried to delve into the extent to which quasi markets may have introduced internal competition between professionals and whether such a factor, if it exists, is undermining the collegiality of the profession. Are individual medical managers seeking to carve out a market niche for their service? Ferlie et al. (1996:179) claim that:

> "There is evidence to show that the fragmentation of units has led to a lack of cohesion among professionals, broken some historical links and caused embryonic competition between professionals."

Similarly, Harrison et al. (1992:103) affirm that "issues of medical dominance has grown, even among clinicians" as tighter resource constraints have widened the gap between the actual and the possible and as new opportunities for diagnosis and treatment are offered by advanced medical technologies.

Critics, therefore, have also focused on the medical - managerial divide and have found a number of, more or less, universal distinctions in the attitudes of doctors and lay managers. In a study conducted in four English and two Australian hospitals, Degeling et al. (2001b: 41) found that lay managers:

> "... strongly ranked accountability to management issues over clinical autonomy issues, took a financial realist stance on issues at the intersection of the clinical and resource dimensions of care; and supported using work process control structures and methods to address hospital resource issues".

In contrast, according to Dent (1991), doctors are said to focus more on clinical work *processes* and less on *structure,* such as facilities and equipment, and *outcomes* such as the condition of the patient after treatment. The same study by Degeling et al. (2001b) found that medical, as opposed to nurse clinicians, are more likely to reject efforts to codify and standardize clinical work or to extend the capacity (of people

other than medical clinicians) to measure, compare and evaluate clinical work performance both between clinical units and within individual units over time.

The study found that differences in approach between medical managers and lay managers are a matter of degree. Sharper differences were evident between collectivist orientations of the nurse clinicians' stance and the individualism of medical clinicians.

> "For medical clinicians, patient treatment is an individual (doctor-centred) skilled performance with a curative orientation. In contrast, nurse clinicians define patient treatment as a collective multidisciplinary process, as much concerned with care as cure" (Degeling et al. 2001b: 46).

Again, the response to current hospital reform varied markedly between occupational groups. For example, nurse clinicians were found to have collective conceptions of clinical work but a non-rationalised[6] approach to work organisation whereas nurse managers who also have collective conceptions of clinical work, tend to have a rationalised approach to work organisation (ibid 2001b).

> "Nurse managers ... were characterised by their concern to promote more rationalised ... and accountable approaches to service delivery ... (and supported) organisational transparency for establishing the accountability of clinicians" (ibid: 40).

Hunter (2000:75 and 67) describes the NHS as a "pluralistic organisation, a loose coalition of groupings all jostling for supremacy, influences and resources ... (and) "each in possession of its own carefully preserved view of the world." However, clinical autonomy has been challenged by restrictions on resource growth, (particularly at a time of rapid technological development), by the removal of the medical veto from formal management structures and the inception of performance indicators and the review process (Wistow 1992). The insistence by the medical profession on ensuring that doctors would remain the ones to "organise and control the clinical processes of diagnosis, treatment and care of patients with no (or

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6 Rationalised approaches are described by Degeling, P. et al (2001b) as "codified, standardized, systematized and transparent"

minimal) concern for the resource implications" of their work (Dent 1991: 67), not only creates the managerial and professional conflict but ensures that "the dominance of the medical profession over other professional and para professional groups and consumers in the UK (remains) largely intact" (Ferlie et al.1996:192).

### *3.7 Public Sector budgets*

The philosophy that underlies the budgeting scheme is that, if information on activity and resource consumption is regularly fed back to a budget holder, he or she will identify and exploit opportunities for increasing efficiency that might otherwise be overlooked. Coombes and Green (1992:282) explain how budgets work.

> "A given level of clinical activity is related to a resource level for a budgeting period usually one year. The budget holders are then charged with moderating their behaviour in accordance with their budget, subject to provisos concerning unforeseen changes in activity, and uncontrollable (external) effects on costs. Penalties and incentives for over - or under-spending are a possible component of the scheme."

Most clinical directors are budget-holders and in 1993 were responsible for budgets ranging between 1.9m and 4.5m (Fitzgerald 1994). Such positions offer an opportunity to manage substantial and often multiple changes in the provision of services and therefore have a "significant influence on the development of a service and to shape practice" Degeling et al. (2001a: 182). Many clinical directors face the need to rationalise services from a number of different sites, introduce quality standards and systems of monitoring standards, develop new modes of service delivery, as well as reduce the number of hours worked by junior doctors (ibid).

Drawing a distinction between *clinical costing* and *clinical budgeting*, Wickings et al. (1983) explain that the former shows clinicians' valid comparisons between how their department spends their money compared to how other departments spend it, whereas *clinical budgeting* involves a participation of both functional and clinical senior staff in order to reach an agreement about service and expenditure plans for the future. Asserting that *clinical costing* is not very effective in reducing costs, Wickings et al. (1983) point to a number of problems: there is no straightforward link

between high costs and medical standards, and deciding a suitable measure of output is a problem which besets clinicians, planners, politicians and epidemiologists. In addition, as the authors point out, in costing systems, outputs need to be broadly suitable for comparisons with other similar services. Finally, direct costs need to be kept separate from other costs. *Clinical budgeting*, on the other hand, is more likely to improve effectiveness and efficiency, though clearly there are some disadvantages, such as the extra cost needed to run the system plus the extra time that doctors must devote to it (ibid 1983).

Wickings et al. (1983:576), also found that clinical budgeting experiments have meant a reduction in waste, such as the elimination of:

> "... unnecessary x ray examinations and pathology tests, quicker treatment on outpatient clinics, more admissions per hospital bed, reductions in lengths of inpatient stay, reductions on ward stocks used by nurses, less food wastage, more productive use of staff and general facilities and the elimination of hospital financial deficits."

As a key element of new public management, devolved budgeting has become a universal model sweeping across the public sector, though it differs in its form and execution across different services. Although the essence of budgeting is made visible through accounting, it is much more than a mere financial tool.

> " 'Budgeting' is of course an economic and managerial process, entailing projections into the future of both physical and financial needs and resources. But budgeting is more than simply a neutral financial or managerial tool. Budgeting is also an individualising process that gives both responsibility and autonomy to subjects. For to be in charge of a budget is to have the freedom to spend as one sees fit, whilst remaining the point at which responsibility resides in cases of deficit and surplus" Miller and Rose (1990:13).

Whilst the quote above emphasises the autonomous qualities of public sector budgeting, Laughlin et al. (1992) more accurately describe it as a model of seeming freedom yet increased control. Since the inception of new public service management came alongside severe constraints in public spending, the 'freedom to spend as one sees fit' is an inept description of what public sector budget holders live out in practice.

Within the NHS, the need to make budgetary controls for doctors seem important stems from a desire to make the health care system more 'accountable.' Therefore, devolved budgets became the medium through which decisions and actions of clinical staff became visible (Jacobs 1995:59). Accordingly, budgets are a medium of organisational transformation and some of the reasons behind the controversial nature of devolved budgeting are that:

> "First accounting systems were seen as a positive response to government requirements for more explicit accountability and a better definition of outputs ...Second, budgets were a device to control doctors. This control was expressed as 'turning clinicians into effective resource allocators' and '...encouraging clinicians to accept responsibility and accountability for their action'"[7] (ibid:67).

Laughlin et al. (1992:130) also emphasise the controlling aspects of the budgeting process, describing it as "a heightened intrusion into defining objectives to be achieved" and including a need for detailed accountability and "measurability of outputs. " The authors conclude, however, that budgeting reduces the freedoms which devolved responsibility is supposed to provide.

In health care, outputs are defined as 'the goods or services that are produced', for example, activities such as the number of assessments or the number of operations produced. However, it is not clear how to measure health output because, as Bourn and Ezzamel (1986:64) explain, output is "not always easy to measure in terms other than workload-related indices, even though some of the activity is highly repetitive." The authors continue that without a clear measure of output, the economic evaluation of clinical practices is both rare and extremely difficult. In addition, "when the environment is in a process of change it is difficult to determine whether output is the product of effort or of the changing environment" (Jacobs 1994:163).

The basic reasoning behind the development of budgeting systems is that clinical judgement becomes visible and management could query the resources used in a clinical unit. Do such systems, however, reflect organisational reality, or are they

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7 Quoting Hopwood 1990

constitutive of reality? Broadbent and Guthrie (1992) suggest that such visibility amounts to the social creation of knowledge because the interpretative scheme used will affect the interpretations of that data. Hopwood (1984:182) also argues more directly that budgeting systems can be deployed to serve political objectives.

> "Procedures for planning, budgeting, and performance assessment can serve to both disseminate and make real the demands of the centre. Constraints on local behaviour can be imposed on the basis of the calculative visibility created by accounting systems. Specific behaviours can be monitored and more readily restrained. The local can, in this way, come to be managed as part of the centre."

Centrally and politically defined indicators of effectiveness and efficiency can become more important than historic data. An excessive procedural concern for accounting and for efficiency could lead to a loss of efficiency in the same way as "plans can become more important than planning; budgets (more important) than the process of budgeting; and costing (more important) than the ascertainment of cost" (Hopwood 1984:183).

According to a Health Committee memorandum, financial data collected suggest that efficiency gains of some 18 per cent were made between 1974-75 and 1989-1990 (House of Commons 1991:8). Since 1984, health authorities were expected to make what were initially termed efficiency savings, and subsequently Cost Improvement Programmes (CIPs) to generate at least 1 per cent growth a year from savings within existing budgets. "However, two National Audit Office reports (1986, 1987) identified the danger of this initiative concealing cuts in the volume and quality of services" (Wistow 1992:111). The principles of adequacy and fairness constantly battle against the need to balance the books.

In the traditional public administration model,

> "the clinician is the patient's agent rather than the agent of the management. While the management of other organisations can require their employees to account for their performance, the primary accountability of the clinician is not to the management but to the patient. Therefore 'because of the uncertainty inherent in human disease processes' and the relationship between clinical staff and patients, bureaucratic controls are not an appropriate way to manage medical

practice" (Jacobs 1994).

In contrast, the Griffiths Report (1983) suggested that the NHS,

> " ... requires the establishment of procedures throughout each District to establish 'management accountant support to Unit managers in the development of their budgets and in monitoring performance against them ... rules for virement between Unit budgets and between individual budgets within the Unit, including the use of planned and unplanned savings ... authorisation limits ... and the financial relationship between Unit budgets and any District-wide budgets for functional services in which the Unit may call' (Griffiths Report 1983:6).

Thus, the report not only recommended a change in the form and ethos of the NHS but a significant structural and organisational change as well.

This new responsibility led managers to reason that a developmental approach towards managing people is a long-term luxury that reduces competitiveness so that the reduction of staff development, the employment of less skilled, and therefore cheaper staff, and finally, the downsizing of human resource capital was seen as the quickest route towards saving money (Clarke, J. et al.1998).

Since at least 70% of all health service budgets are spent on human resources, the Griffiths report may be said to have had an important impact on human resources, as holders of management budgets were to become involved in such allocations in response to the need to "sharpen up the questioning of overhead costs" (Bourn and Ezzamel 1986).

The inception of the Management Budget Initiative (MBI) is another important aspect of the Griffiths enquiry. It was initially meant as a means to ensure more effective management, but subsequently it was widely perceived as an accounting initiative because, apart from being concerned with the management structure, it also draws on the notion of achieving value for money and "the key personnel involved with its implementation included accountants" (Wistow 1992:17).

There is the pressure to use resources more economically and that justifies "an impetus toward measurement, calculation, analysis and cost control" (Coombes and Green 1992:293). As such, budgets have also been perceived as a covert device for

reducing overall resources. Ferlie et al. (1996) point out that when budgets are allocated between competing providers, incentives for performance at the level of the individual providing organisation are sharpened. However, certain cost constraints are not imposed by competitive markets but are set in relation to levels of adequacy based on 'objective' standards. Who, therefore, decides these standards: new expertise, old traditions, new management cultures, or new technologies? Indeed, advancements in medical technology create new standards in medical practice which intermingle with the expansion in computer technology.

> "The rapidly maturing hardware and software of information technology is creating ever expanding possibilities for the capture, transmission and manipulation of the data involved" (Coombes and Green 1992:293).

Technological expansion also means that reforms are passed "because they can be technically done not because they really need to be done" (Humphrey et al. 1993). Indeed, the production of accounting numbers is also a social process which depends on an intermingling of various interests (Broadbent and Guthrie 1992).

From the budget holder's perspective, budgets can often be seen as a "bureaucratic nuisance and irrelevancy" as well as a "a breakdown in trust" (Laughlin et al. 1992). A study by Jacobs (1994:162) revealed that:

> "most of the clinical staff involved in this process suggested that budgets were given to them without consultation. Many clinical directors found that their new role was quite different from what they had expected. They believed that they would receive control of a flexible budget. However, most found that budgets were basically fixed and they had little control over either budgets or work levels."

According to Miller and Rose (1990), budgets tie individuals 'into networks of calculation' and they are limited to 'centres of calculation.' As figures and accounts flow back and forth from centres to the budget holders, the individual is made 'calculable' and 'made to calculate.' "Clinical directors have no real power or influence ... (nor do they) have control over the resources" (Jacobs 1995:70).

Budgeting calls for new requirements such as planned activities and a detailed knowledge of the opportunity cost to other activities within a tight and cost effective

service. Such 'intrusion' and 'control' have been perceived by many health care practitioners as a reduction of *clinical freedom for patient care* - a concept underlying the hospital service culture. Bourn and Ezzamel (1986) maintain that accountability to others for strictly clinical decisions is seen as an erosion of a long-standing culture. Even when the responsibility of scarce resources is given to those responsible for their allocation, clinical freedom is still seen as diminished (Broadbent et al.1991).

The burgeoning trend towards accountingization within the public services can be described as a form of central control which at best may be said to regulate resources and at worst to dominate and frustrate the humanitarian aspects of public welfare. Budgeting reforms have resulted in organisational restructuring, whilst budget ceilings have been conceived as constraining the evolutionary development of the health care system, which is expected to respond to technical, scientific and management breakthroughs.

If transparency is meant to be the fundamental goal of budgeting, the two opposite faces of the budgeting process (regulation and domination) need to be uncoupled and dealt with separately. Public sector budgeting could prove to be a worthwhile experiment if an increase in datasets collected on finance, workforce utilization, and clinical activity results in clarification. Wickings et al. (1983:477) also add that clarification emerging from the budgeting process can be an advantage especially "when governments are thought to be implementing cuts by stealth."

### *3.8 The growing gap between social policy guidelines and implementation*

Implementation gap theory is described by Dent (1991: 66) as the "failure to implement the complex and ambitious social policies and programmes launched by 'big government.'" Analysts such as Pressman J and Wildavsky (1973) agree that the goals of the original policy makers are often subverted during implementation, which means that organisations tend to transform policies. At the macro level central government policy is expected to influence local delivery organisations to behave in certain ways. At the micro level, local organisations usually resort to devising their

own internal policies (Dent 1991). Not only does the public sector workers' intense involvement in their own micro perspectives lead to a distancing from central health or social policy guidelines, but internal policy clashes become highly probable as economic, managerial and professional expertise vie for the best policy solution. According to Lipsky (1980), the extent of the implementation gap depends on the adequacy of resources in relation to the tasks workers are asked to perform and on whether the goal expectations of public sector workers are clear or ambiguous, vague, or conflicting. Huge caseloads and inadequate resources combined with the uncertainties of method and unpredictability of user needs can all undermine the public workers' intentions (ibid). Another issue that is problematic is that once a service becomes available, it tends to increase demand, thus constraining resources further so that successful services become 'victims' of their own success. In recent years, public services are more likely to experience the opposite trend such as cuts in services or, failing that, an increase in the ratio of clients or cases and time against the number of public sector workers available.

These cutbacks often stem from the notion that general managers must implement cost constraints or get sacked. Management strategies, themselves, are likely to be a trade-off between capitalist imperatives emerging from the centre and the corporate intentions of the organisation (Dent 1991), though Harrison et al. (1992) suggest that the prevailing culture, resource context, organisational relationships and other uncertainties are more likely to act as powerful determinants of policy implementation than general management. Lipsky (1980) however, stresses the power given to managers, arguing that whilst the role of the public sector worker is to secure the requirements of completing the job,

> "Managers, on the other hand, are properly result-oriented. They are concerned with performance, the cost of securing performance, and only those aspects of process that expose them to critical scrutiny" (ibid: 19).

Public sector reforms such as the new public management is likely to increase the implementation gap as the managerial regime requires shifts in the distribution of "authority, money, time, attention and rule-making capacity." This new regime has been described as eroding "commitments and understandings" and undermining the

"values, meaning, practices and rules" which are central to the public sector worker (Degeling et al. 2001a). However, even before the inception of the new public management ethic, managers were often pressured into neglecting the qualitative aspects of service delivery in order to give more attention to cost and volume reductions. Writing in the late 1970's, Lipsky (1980:179) notes that quality is sacrificed in the name of efficiency and productivity as public managers are expected to improve their control over costs and resources deployment.

### *3.8.1 Public sector workers and the implementation gap*

According to Lipsky (1980:29), street level bureaucrats[8] work with "a relatively high degree of uncertainty because of the complexity of the subject matter (people) and the frequency or rapidity with which decisions have to be made." They usually have very large caseloads relative to their allotted time and often unable to fulfil their mandated responsibilities. Often they are pressed to handle a large number of service users at one time, which could mean "reversing the values instilled in them during their training" (ibid). Lipsky further explains that to deliver a service through a bureaucracy is a contradiction in terms. The street level bureaucrat's detachment and equal treatment under conditions of resource limitations and constraints do not sit happily with fair treatment, care and responsibility towards the service user. The processing of large amounts of work with inadequate resources means that the implementation of social policies is both conditional and discretionary. The launching of a new service brings in, not only an increased demand, but may also require personal resources for which workers may be inexperienced or under-trained. Whilst street level bureaucrats may declare their intention to be more user-focused, it is often impossible for them to fulfil user needs as:

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8 Street level bureaucrats are "public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work." Street level bureaucrats would include: "teachers, police officers and other law enforcement personnel, social workers, judges, public lawyers and other court officers, health workers and many other public employees who grant access to government programs and provide services within them" (Lipsky 1980:3).

> "They are constantly torn by the demands of services recipients to improve effectiveness and responsiveness and by the demands of citizen groups to improve the efficacy and efficiency of government services" (Lipsky 1980: 4).

Lipsky (1980:77) lists four key reasons as to why public sector workers can become alienated from service users:

- They tend to work only on segments of the product (or service) of their work. For example, positions tend to be filled with specialists who cannot take full responsibility for the service even if they wanted to.
- They do not control the outcome of their work.
- They do not control the raw materials of their work.
- They do not control the pace of their work.

Ultimately, public sector workers adjust to the lowering of expectations for themselves and the public and they are forced to develop shortcuts and simplifications to cope with the press of responsibilities. Indeed, Lipsky (1980:76) even goes on to state that street-level bureaucrats "devote a relatively high proportion of energies to concealing lack of service and generating appearance of responsiveness."

Street-level bureaucrats "hold the keys to a dimension of citizenship" because they "may be understood to "make" the policies they are otherwise charged with implementing"(ibid:44). Policies carried out are borne out of their established routines and coping devices, and eventually, their inability to catch up or remove themselves from the pressure of work desensitises them from the human dimension of their job (ibid). Thus, conflict is expected to surface at the worker-citizen interface as the needs of individual service users clash with "routinization", "mass processing" and "efficient agency performances." Therefore, the ability of public sector workers to treat people as individuals is significantly compromised by the needs of the organisation to process work quickly using limited resources at its disposal.

### *3.8.2 Implementing health care policies*

In the past, managers were prepared to accommodate uncertainty and ambiguity within an environment where a problem can have a number of different definitions as

well as contradictory objectives (Harrison et al. 1992). Previously, therefore, non-assertive managers accommodated doctors who had more discretion and autonomy than most other public sector workers in implementing social health policies. Since the 1980's, however, the position of managers in the NHS has been undergoing continual transformation.

> "Whereas in the Thatcher era of the NHS internal market, managers generally felt empowered and in charge of events, they now appear cowed and beleaguered functionaries in a system that is more politicised than ever and whose political heads regard themselves as leaders. Far from being engaged in the shaping of policy and its implementation, managers feel excluded and marginalized" (Hunter 2002:66).

Clinical work is now subordinated to the demands of clinical governance and financial management and new notions of 'informed consumerism' have displaced old notions of 'medical paternalism'. Yet, hospitals are non-market organisations having to face changing pattern of diseases, increased medical specialisation and the application of newer and higher medical technologies. Despite all of this, policy authorities are increasingly pursuing accountability systems which are often divorced from social needs. Some of the consequences of increased monitoring are distrust and a related crisis in confidence (Harrison et al. 1992). Within such a setting, health policy implementation loses it immediacy and significance.

Another problem affecting policy implementation is the different approaches to health care amongst different groups of health care professionals. Not only is the NHS made up of multiple groups and interests who do not necessarily share the policy goals emanating from higher levels in the organisation, but also the structural configuration of medical mangers could potentially trigger off further conflict. In a study, by Degeling et al. (1999:225), it was found that,

> " ... the development and implementation of work process control structures will require medical managers to question their medical colleagues' claimed right to self define, self describe, and self validate their work. Our findings suggest, however, that the attitudes, values and beliefs of many medical managers will inhibit them from challenging their erstwhile clinical colleagues in this way".

Even if the intrusion into and the questioning of clinical decisions causes no serious conflict, the awareness alone of such policing procedures is likely to impact on policy implementation one way or another. Degeling et al. (1999:44) found a significant difference in attitude between lay and medical managers, with the former showing a preference for "rationalised and transparent approaches to work organisation" whilst the latter showing a preference for "nonrationalised and nontransparent approaches to work organisation". Nevertheless, Harrison (1992:148) points out that 'management' is not perceived as "a fully paid-up member of the NHS tribal club – it is seen (quite correctly in our view) as having divided loyalties." Degeling et al. (2001b:37) suggest that a way round the conceptual differences between clinical and managerial perspectives is for managers to develop "a shared discourse for establishing their managerial identity and mediating between nursing, medical and managerial conceptions of what is required to improve service provision."

The profuse and unstable range of values and priorities, the ambiguity of targets to be achieved, in brief, the requirement "to integrate financial control, service performance, and clinical quality at every level of their operation" (Scally and Donaldson 1998), may leave no room for the implementation of the kind of social health policies which fully takes into account the service user's perspective.

The policy implementation gap within the NHS is exacerbated by new technologies which invite fresh demands from service users. Spiralling costs increase the pressure on both managerial and non-managerial staff to ration resources. Within the NHS, cutting down on resources, for example the number of beds or number of staff, may decrease service user expectations but such decisions do not necessarily decrease demand. Other critiques concerning the implementation gap have focused on the discrepancy between reality and stated policy intentions, which Lipsky (1980:72) calls " the myth of service altruism", pointing out that "politicians and administrators regularly discuss levels and amounts of care that will be provided, but rarely who will care, and how they will express their caring" (ibid). Effectively, citizens are socialised into expecting inferior or inappropriate services within a system which

treats parts of people rather than the whole person. This concern has been partly addressed by the present administration through the introduction of the joined-up policy initiative, whereby different agencies work together to tackle complex issues.

Gunn (1978) sets out ten preconditions for achieving perfect implementation. Some of these include the nature of external circumstances; amount of time and other resources available; specified tasks for each participant; an agreement on objectives, perfect communication and coordination; perfect obedience to those in authority; a valid theory of cause and effect and a requirement of a single implementing agency. This list, which makes social policy implementation virtually impossible, omits the possibility that people, whether they are public sector workers, or service users can be flexible, co-operative and very resourceful in any given social situation, including the context of public service delivery.

As Lipsky wrote more than two decades ago, we are left with two alternatives,

> "... to drift with the current turmoil that favors reduced services and more standardisation in the name of cost effectiveness and budgetary controls; or to secure or restore the importance of human interactions in services that require discretionary intervention or involvement" (Lipsky 1980: xv).

### *3.9 Summary*

New Public Management is a broad overarching term which embraces multiple political, accounting and managerial choices. It is not "a homogenous set of practices across the public sector" (Ferlie et al.1996:166) and can be understood as replacing the old public administration ethos. In general, it can be said that public services in the UK have become more businesslike and critics might add that whilst managerial responsibility has improved, political responsibility has been attenuated. The transition from public administration to NPM is due to a number of drivers: the neo-liberal political and ideological climate; a decline of deference towards some of the professions; a rise in the importance of management functions and the creation of powerful information technology and information systems (McLaughlin et al. 2002). Some of the elements of NPM have been identified as being: devolved budgets (with

their accompanying mission statements business plans and managerial autonomy); accountingization (with its focus on productivity: inputs and outputs); internal markets; fiscal prudence (for example, the increasing number of short term contracts, performance-related pay and individualised job contracts); measurable standards of performance (using comparative databases for external audit, performance review and benchmarking); and a decrease in trust in professional standards and expertise.

De-democratisation and increased central control are perceived as two key features of the new managerialism with its substitution of econo-legal principles for traditional administrative law. Whilst NPM "is seen as strongly shaped by the combined forces of the legislature, government and (elite) professions (who historically have) a strong alliance (and are) accorded substantial influence and (mutually reinforcing) self-regulatory capacity", social policy analysts' views as to the success and or desirability of the NPM revolution are mixed (McLaughlin et al. 2002:11).

Whether or not the old values of universalism, equity, democracy and public service were practised before the rise of NPM, the organisation of the NHS and other public services has clearly changed with critics arguing that these 'old' values are even more difficult, if not impossible, to practice within the current climate change. Efficiency savings and the expectation to stay within financial targets is given more attention than the need for quality assurance considerations, such as, the extension of visiting hours and a host of other user needs.

The scrambling and unscrambling of the health services organisation has been theorised as a change in culture underlined by a reshuffling of who has power and control. The current administration adopts neither the command and control style of the 1970s nor the competitive quasi-market approach of the 1990s, but a so-called partnership - a "collaborative approach based on networks resulting in a top-down approach which the government allegedly rejects." The current Labour government "more than any other government since the 1970s ... has proved to be the most managerial and technocratic" (Hunter 2002: 76 and 70). Referring to the current hard line managerialism, Hunter (2002:74) observes:

> "Under New Labour, relationships have not improved and may in fact have deteriorated. Despite the government's insistence that the market is dead and that 'joined-up' policy and partnership working are back in favour, few feel assured by the government's aggressive top-down management style."

NPM has been adopted for diametrically opposite reasons in different contexts. It is built on an ideology which clarifies goals in advance and then builds accountability systems in relation to those preset goals (McNulty and Ferlie 2002). One way of making public sector workers accountable is through the budgetary process. For health care practitioners, a rigid focus on financial information is apt to diminish their clinical freedom as budgeting and accounting systems can define the nature and volume of their tasks as well as the evaluation of the medical care they deliver. Although the accounting logic would seem to provide a technology for implementing a control of professionals, its *prima facie* functions are to 'factually' represent through its allegedly neutral, objective, independent and fair information and to emphasise notions of standardisation through a common measurable yardstick. Yet, it clearly creates certain visibilities and downplays anything else which is not deemed important (Broadbent and Laughlin 2002).

Within public sector organisations, implementation of policies is a complex process. Lipsky (1980) provides a studied explanation of how and why street level bureaucrats fail to put policies into practice. More recently, the procedures of NPM alongside funding constraints are reported to have made policy implementation even more difficult whilst the organisational and structural confusion it has created within public service institutions ironically coincide with patients' charters and an accent on user choice.

### *3.10 Economic rationalism, social health policy and the fieldwork*

One of the outcomes of the crisis in funding the welfare state is a crisis of confidence in the means of existing delivery systems to manage services effectively where staffing levels have been trimmed and/or roles diverted. Critics of NPM have suggested that economic efficiency has resulted in a rapid disintegration of public

service provision as well as a destabilization of traditional public service values such as 'the public good'.

The macro objective of this study is to explore the extent to which the values underlying British social policy are changing because of the economic rationalism underlying the new public management regime. The NHS has been the target of a number of organisational, structural, administrative, and not least fiscal changes especially since the publication of the 1983 Griffith's Report, described by Pollitt (1993) as the template of the new public management in the NHS. Ten years later *Changing Childbirth* (Cumberledge Report 1993) placed women's choices at the centre of maternity care. How feasible is the implementation of this particular health policy within the existing managerial framework?

Through empirical research with health care practitioners, this study examines how maternity care policy is deployed within an econo-rationalist framework. It explores the limits of policy statements which presume to put the service user's health and welfare first, and, through in-depth interviews with maternity care practitioners and budget holders, explores how and why monetary values are attached to diverse aspects of maternity care. This research tries to address how funds, information and medical knowledge are processed and the impact of these on two different organisational structures.

# Chapter four

## Design and Methodology of the Enquiry

### *4.1 Introduction*

Bowling (1997:103) describes a research paradigm as

> "a set of assumptions upon which the formulation of research questions are based – deriving from a way of looking at the world and assumptions about the nature of knowledge."

In this study, the set of assumptions, which shape the research questions, are based on economic rationalism as expressed through the NPM framework. Selected aspects of the new managerialist paradigm are tested against the empirical realities revealed in the two case-study settings.

Using NPM as a 'theoretical'[1] framework, however, raises a number of problems. *Firstly,* there are some disagreements as to what constitutes NPM and doubts have been cast regarding its coherence as a system of management. NPM's roots are eclectic. They may be described as a cocktail of political science, economics and management and organisational studies and they do not have a uniform impact on public services. For example, McNulty and Ferlie (2002) argue that the decline of traditionally strong trade unions and the rise of managers and markets in the 1980s and 1990s may be played out in different organisations in various ways. Yet, despite

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1 NPM is understood to be a set of policy imperatives based on economic rationalism. Its widespread use in recent years has been underlined by an implicit theoretical assumption that public services can be run efficiently and effectively by borrowing private sector management techniques. Depending on the context, NPM can be understood, on the one hand, as an economically rational tool and, on the other, as a nascent theoretical model that supposes best practice in the public sector.

its presumed lack of uniformity (if not coherence), the proliferation of NPM has revolutionised the way the public sector is organised compared to twenty years ago. It has bought about a "macro-level change to the form and functioning of public agencies" (Ferlie & Mack 2002:311). The comparison of the two case studies in chapter seven tests out this assumption to a limited extent. *Secondly,* NPM is an evolving system and the researcher needs to be alerted to the possible instability of his or her findings. Even if NPM is evolving and unstable, organisational changes have become a 'constant' feature within the NHS. Some of the findings in the chapters that follow demonstrate participants' perceptions pertaining to their strained recovery from previous organisational changes and the anticipation and anxiety of changes to come. Findings, therefore, reflect the nature of the current organisational turbulence which is linked to an evolving NPM model.

*Thirdly,* NPM offers multiple levels of analysis and a wide possibility of foci. I narrowed down my investigative focus to the health services, and specifically to maternity care, to test out the impact of NPM on the implementation of the recommendations set out by the Cumberledge Report (1993). Given that before the inception of NPM public services were not being executed optimally, does its onset improve or compromise the integrity of social and health policies even further?

McNulty and Ferlie (2002:87) distinguish between the outer context, that is the "wider societal changes or shifts in the political economy" and the inner context "the micro-politics and culture of a single organisation." In this study the NPM paradigm forms the outer or macro context whilst the organisational setting of two sites forms the inner or micro context. At the intermediate or meso level a number of developments such as the National Institute for Clinical Excellence (NICE), new regulatory agencies such as the Commission for Health Improvement (CHI) and new auditing initiatives are also meant to shape the professional and managerial process NHS-wide. In tandem with these developments, social health policy recommendations such as the Cumberledge Report (1993)[2] set out fresh

[2] See chapter one for a fuller account of the Cumberledge recommendations

recommendations for maternity care provision concerning, *inter alia*, service user choice and continuity of care.

This dissertation explores how the Cumberledge recommendations fare within a wider NPM context. Whilst economic rationalism may have pressured maternity care units to share different degrees of work intensification which have an important bearing on policy implementation, neither NPM nor the Cumberledge Report (1993) is likely to have had a uniform impact on maternity care units. The fate of financial and political imperatives "are closely tied to the conduct and perceptions of key individuals who are involved in sponsoring or blocking change" McNulty and Ferlie (2002:94). This study explores how and in what way clinical action and perception, which is embedded within these structural changes, is constrained or freed by the dynamics of the various organisational tiers, and within such a context, what importance is given to social health policies such as the Cumberledge Report.

As the earlier chapter illustrates, new managerialism is a multifaceted movement and whilst the NPM concept may, in theory, be analysed separately from financial concerns, in practice it is inextricably linked to economic rationalism. In part, this thesis presumes that NPM is a collection of tools and techniques through which neo liberal economics can be fully implemented. One feature of NPM which clearly links it to economic rationalism is devolved budgeting, a process which differs in its form and execution across different services. Budgeting is meant to give the public servant in charge of it the freedom to spend as he or she sees fit. Ultimately, however, it may also be deployed as an economic and managerial tool of control. In this study, the impact of the budgeting process on maternity care policy is a key element. Cash allocations can constrain or free the patient as well as the clinician-patient relationship and the way that funds are allocated can reveal expressed priorities. In theory, with decentralised fund holding, the government's recommended 'quality care' ought to be more easily attainable. In practice, how, if at all, has NPM's ascendancy been shaping the interpretation of quality care? How are social health care policies being interpreted and applied by clinicians practising within the new managerialist ethic? This study sets out to answer these questions through in-depth

qualitative interviews with health care managers and practitioners[3]. In the chapters that follow, two key policy recommendations proposed in the Cumberledge Report (1993) are examined against the budgeting priorities.

Maternity care is an appropriate place to study the evolution and impact of EC/NPM because maternity care provides for a powerful user groups[4] that have clearly identified their social priorities and, therefore, most likely to achieve them. I also expect that some participant midwives and obstetricians might have been maternity care service users, hopefully allowing them to demonstrate an understanding of the service user perspective. Finally, I have some experience as a service user and, therefore, some insight, into the service users' perspective.

It was decided to interview health care practitioners as opposed to service users owing to a number of factors.

- Service user interviews are not likely to yield direct insights into the workings of NPM.
- Interviews with individual service users are not likely to convey an overall picture of the way resources are distributed.
- Service users are likely to reveal very little about the unit's internal ethos
- It is the practitioner, rather than the service user, who is likely to have some key insights into maternity care budgets.
- Service users can only single out subjective one-off experiences and, therefore, are not able to convey a global picture.

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[3] Participants from both units included general managers, obstetricians, paediatricians, midwives and other maternity care practitioners.

4 This influential group may not constitute more than 20% of all service users. Nevertheless, their proposals have made an impact nationwide.

- The numerous and divergent views of service users have already been abundantly documented (Garcia 1998; Amos et al 1988; Gready et al 1995). These and other secondary sources are incorporated into the findings.

Although it was generally felt that, for the purpose of this study, the exploration of the implementation gap between social health policy and practice is best served by interviewing practitioners, it is acknowledged that patients' perceptions of maternity care provision can, at times, be seriously at odds with that of practitioners, and in a larger study, the incorporation of service users' perceptions of the quality of maternity care would have produced a more comprehensive picture.

### *4.2 The setting*

The study took place in Scotland where two[5] highly contrasting maternity units, in terms of size, internal culture and geographical location, were investigated. Crighton[6] is a very large maternity care unit set in an urban environment, and Bingham is a medium sized unit set in a smaller urban environment. The former is a conglomeration of several maternity units, effectively four disbanded units rolled into one. Smaller units have been closed down in recent years in the face of major community opposition. This process was taking place in Bellham Trust at the time of conducting the fieldwork. Bingham was in the throes of merging with Warnick, another medium-sized unit, to form a newly centralised maternity unit.

Crighton and Bingham are unique in many ways. The former is one of the largest maternity care units in Scotland whilst the latter is one of the few units that operate an integrated team midwifery system[7]. Whilst doubts may be cast on the representativeness of this study, the historical and political value of these findings is very significant. Crighton, a hyperunit, represents, in some ways, the future of

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[5] Fieldwork took place mainly in two sites: Crighton maternity unit and Bingham maternity unit. Additional findings from a third site, Warnick maternity unit, are also included owing to its pending merger with Bingham.

6 The names of the maternity units have been altered to protect confidentiality.

7 See chapter five for a fuller explanation

maternity care because of the present trend to centralize maternity care provision. On the other hand, Bingham, represents, in many ways, all that is organizationally possible in a medium sized unit.

There are a number of methodological advantages in comparing two distinct maternity units belonging to two different Trusts. *Firstly,* since Trusts are, to a large degree, financially autonomous and self-governing, certain budgetary aspects will differ from one Trust to another, therefore yielding insights into pervasive aspects of NPM. *Secondly*, a comparison between the two units allows a comparative insight into the processes and mechanisms that permits the various levels of service user choice and continuity of care offered. This comparison has helped to map out the organisational setting that is likely to maximize continuity of care. Moreover, since Crighton is an amalgamation of smaller units and Bingham was in the throes of merging with another unit, the centralisation of maternity services became an important consideration, in terms of cost and quality of maternity care, as fieldwork advanced.

Primary data gathered from the two autonomous and self-governing Trusts have yielded both similar and contrasting facets of budgeting and conceptions of good quality maternity care. To a limited extent, the comparison effectively tests out the generalizability of the findings and brings into sharper relief vital links between budgeting process and the nature of two of its presumed end products: service user choice and continuity of care.

### *4.3 Fieldwork*

Prior to commencing fieldwork, I sought and gained permission to access staff in Crighton Maternity Unit and Bingham Maternity Unit through the Medical Director and Clinical Director respectively. I also sought and gained ethical approval from the

secretary of the Reproductive Medicine Paediatric Sub-Committee[8].

In the process of searching for an understanding of what does take place when budgets are translated into maternity care[9], I left myself open, whenever necessary, to the elimination of any clearly erroneous suppositions on my part. This approach was one that allowed for conspicuous openness during fieldwork interviews: it assisted both the exposure of latent 'theories' as well as the affirmation of existing ones. Grounding my enquiry in the core of the participants' perceptions meant that my analytical conclusions were driven to a certain extent by their original accounts and observations.

Defining what maternity care might entail can be a complex as well as a limiting exercise. In the search for an understanding based on practice-based realities, I proceeded to distil some key *values* underlying maternity care as perceived by practitioners themselves. After some preliminary interviews, it became evident that practitioners, in particular midwives, held user *choice* and *continuity of care* as two very important principles which, following the Cumberledge Report (1993)[10] began to be regarded as the hallmarks of maternity care. The next step, therefore, was to find out the extent to which budget holders consciously take into account the declared importance of these values when making financial decisions.

From this point onwards, I set out to investigate the extent to which resources were being made available to allow these principles to take place in practice. What are the links between resource allocation and the upholding of the principles of *choice* and *continuity of care*? Is there a basic standard that is adhered to despite differences between one maternity unit and another, between medical and midwifery staff and between clinical and managerial staff working within the same maternity unit?

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8 This is a sub-committee of the Health Board's Research Ethics Committee. Once I received the go-ahead for the first unit, it was not necessary to seek approval again from the Health Board of the second maternity unit.

9Here the definition of Maternity Care is limited to two social health policy aspects: service user choice and continuity of care.

10 *Provision of Materntiy Services in Scotland A Policy Review* (1993) SHHD is the Scottish version of this document outlining matching social policy health values.

Before embarking on the fieldwork side of this enquiry, a clear understanding or, at least, a focused grasp of the nature of maternity care provision and finance was gathered from secondary sources. These included official reports, ethnographic and quantitative studies, official statistics, financial reports and other materials, some of which are cited in relevant parts of the thesis. In contrast, the fieldwork was expected to provide me with important insights into the trade-offs undertaken between acceptable levels of service user *choice* and *continuity of care,* and *available resources.*

The fieldwork process was layered. Firstly, in order to establish the foundations of this enquiry, I sought to bring to light the principles or values underlying maternity care as perceived and understood by the participants. Secondly, I sought to sharpen my understanding of the key factors uncovered at phase one through further interviews and further reading of secondary literature. Thirdly, I interviewed budget holders in search of the vital links between providing maternity care and financing it.

The purpose of the study was explained to each participant, her/his consent was sought and he/she was informed of the right to stop proceedings. Tape-recorded in-depth interviews of around 45 - 90 minutes each were carried out with a sample of 43 midwives, obstetricians, and other key informants. The initial two or three interviews were pilots allowing a more appropriate interview schedule to be phased in. Thereafter, I proceeded with another six phase one interviews. These dealt with very broad and ambitious questions[11] stemming from new public management literature as well as my own experience of management cultures within the public sector. The issues under investigation were initially extensive. These included six areas: i. management styles (health policy and finance); ii. staff policy and empowerment (including cost consciousness); iii. application of new medical knowledge iv. perceptions of standards of care v. access to quality information, training and new technologies and vi. cultural differences and expectations of patients and staff. The interview schedule was not necessarily strictly adhered to. Adjustments were made to

[11] Interview schedules at various stages of fieldwork are listed in Appendix 1 and 2

take into account the *modus operandi* of the individual hospital environment as well as the designation of the participant. As the fieldwork advanced, the sort of questions put to health care practitioners became more sharply focused. It became clear towards the end of phase one interviews that participants, particularly senior and junior midwives, demonstrated a focused concern for the Cumberledge Report (1993). A global overview of responses suggested that *continuity of care* and service user *choice* influenced, underlined, and sometimes directed most of the participants' responses. This finding gave me an operational understanding of maternity care and subsequently service user *choice* and *continuity of care* were adopted as key organisational elements for analyses.

This meant that at this stage, a new interview schedule was devised and administered and Phase Two interviews with budget holders were directly linked to service user *choice* and *continuity of care*. Questions were adjusted according to the clinical and/or financial role of the participant. At the same time I allowed participants to vent their views on closely related topics if they were so inclined - thus allowing broader and fresher insights to emerge. The interview schedule, which can be found in Appendix 2, was used as a general guide for interviews with i. budget-holders; ii. midwives; iii. senior midwives; iv. junior doctors; and v. consultants. Since interviews at Bingham followed those at Crighton, the interview schedule for Bingham participants was adjusted to match its distinct organisational setting.

An examination of how new managerialism impacts on maternity services was conducted through an investigation of individual and shared perspectives of maternity care practitioners and budget holders. The study enquires into their understanding of the constraints and freedoms resulting from organizational priorities and officially imposed levels in cash allocations, and how they think these shape the provision of maternity care in each of the two settings.

### *4.4 How the enquiry was designed and conducted*

The research design consists of a merger of two opposite methodological approaches. One is the approach advocated by Miles (1979) which is the setting out of an

organisational framework; the other is the grounded theoretical approach characteristic of Glaser and Strauss (1967). The combination of these two approaches corresponds to McNulty and Ferlie's assertion.

> "In qualitative work, there is a tension between the need for focus and letting issues and themes evolve out of the data collection process in an emergent or a grounded way" (ibid 2002:104).

This combined method effectively meant that it was not possible to envisage the quality and quantity of the data to be collected nor its analytical and theoretical potential. Indeed, early empirical findings led to the need to collect and access further fieldwork-relevant literature.

The design of this study can be described as informed by grounded theory as it was, in part, allowed to evolve over time. This flexibility enabled a number of new and unanticipated subsidiary themes to surface from the interviews. A firm attempt was made throughout to avoid foreclosing ways of construing and addressing the emergent issues that are broadly linked to NPM. Consequently, fieldwork generated extensive data as well as multiple perspectives by participants discussing the same issue. Nevertheless, there remains a distinct approach to maternity care in each of the site localities under study.

In recent years, there has been an increased interest in health care qualitative research (Pope and May 1995; Murphy et al 1998). Some writers warn that caution needs to be exercised when interpreting verbal feedback because this is not the result of 'scientific' study. The traditional scientific method of investigation presumes two features. Firstly, that the object being studied is a stable and fixed phenomenon. Secondly, that the subject observing the object is unchanging, equipped with maximum powers of observation, is unaffected by or does not interact with the object in an obvious way and, therefore, has no influence on the 'behaviour' or 'substance' of the object studied. None of these are true with respect to the investigation I have conducted. However, this does not mean that there are no substantive residual phenomena that can be described as having a social, political, and cultural reality. Certain practices, values, beliefs, and cultures are deeply ingrained and are,

therefore, observable. The existence of these slow changing factors is not only observable empirically, but is also supported by similar studies.

During fieldwork, interviews were adjusted flexibly according to the practitioner's role, approach, mood, personality and belief system. There was a conscious attempt to allow the participant's viewpoint to come to the fore using thought provoking prompts whilst allowing the occasional discussion and mutual exchange if it was felt that the participant was looking for such. Blum (1984) describes these interactions as 'interview conversations'. It would be inaccurate to suggest that each and every participant was asked exactly the same questions and more accurate to state that the conversational style employed ranged from semi-structured (topic based) to unstructured (allowing the personal agenda and experience of the participant to surface) approaches. The *first priority* was to keep the interview within the confines of the NPM and Cumberledge framework. *Secondly,* the participant was given the opportunity to expand on any relevant points even at the expense of missing out certain questions. Indeed, such a situation often rendered subsequent questions redundant as the participant sometimes automatically covered the unasked questions. *Thirdly,* the participant's personality was seen as impinging on his or her description of a particularized situation as well as on the perception of his or her clinical role. This interactive and relaxed approach gave the participant maximum freedom to raise new issues and avoid awkward ones. This 'permissive atmosphere' (Blum 1984) or 'opportunities approach' (Buchanan et al 1988) maximised the cooperation of the participant.

Sometimes the participant set the tone of the interview and came prepared with an agenda and perspective s/he wanted to sound out. This openness threw considerable light on my own reality model and brought in fresh ideas as to how service providers think and function. The tendency was to continuously shift towards the participant's view of reality so as to gain maximum insight. Each interview created its own dynamics depending on the status of the participant as well as his or her individual expectations of the interviewing process. This type of interactive research culture

combined restraint (an awareness of sensitive issues) and letting go (a willingness to be led).

Well-read participants tended to be very influenced by the terminologies of current policies, viewpoints, and leading perspectives. The way they said they experienced maternity care as service providers was evidently a mixture of their day to day experiences augmented by what had been read and heard from others. At the same time it became apparent that the more they read, the more influential they were towards assisting others form an opinion about what is 'really' happening.

One problem is that there was an impression at times that participants assumed that I was researching with a service user bias as they sometimes bent over backwards to insist that the service user always comes first. Sometimes I felt that this bias often screened off internal problems that participants did not wish to discuss. Clearly, any sort of internal problem has a negative impact, directly or indirectly on service users. In such situations, I have tended to include the observed nuance in the voice (e.g. *answers hastily; does not sound self-convinced; hesitates)* when transcribing from audiotapes.

There did not seem to be any serious clashes between academic and clinical discourses. The interview schedule usually worked as a guide. Questions were adjusted to suit the participant's role, personality, and mood of the moment. On my part, I requested, if and when necessary, an explanation of any unfamiliar medical terminology. In general, my interviewing approach was underlined by honesty and self-correction permitting a reconsideration of any assumptions and presumptions.

Whilst the study does not ignore the service users' perspective, this is not its central concern. It is less about finding out whether or not user choice and continuity of care as recommended in the Cumberledge Report 1993, are being put into practice and more about the practitioners' understanding of these policy principles and their perception of the constraints and freedoms which dis/allow them to put them into practice. Essentially this is an ethnoscientific study of the perceptions of insiders

looking in - analysed and reported by an outsider and non-user looking in. Leininger (1985:85) explains ethnoscience as:

> "... a formalised and systematic study of people from their viewpoint (the emic[12] view) in order to obtain an 'accurate' account of how people know, classify and interpret their lifeways and the universe. The goal of ethnoscience is to discover, document and make explicit cognitive knowledge from the people's viewpoint, the 'inside view' rather than "outsider viewpoints."

Ethno data is perceived as a key method in research into organisations. Through ethno research it is possible to discover and communicate an organisational reality as it is perceived by the inhabitants of that reality (Stablein 1996; Hammersley and Atkinson 1995).

I have attempted to interpret the findings of this study in a balanced, adaptive, flexible, reflexive, and rigorous way. A grasp of the relevant processes relating to cost, continuity of care and service user choice was feasible through the adoption of an open and enquiring mind using (i) strategic investigative skills and (ii) by interacting with participants sensitively to ward off premature closure. My approach was exploratory and open to contradictory responses whilst retaining a clear focus on the general framework of the enquiry.

### *4.5 Justifications*

This section examines the extent to which my findings are reliable, representative, valid, and rigorous. Whilst the fieldwork approach has been one of openness and flexibility, the overall tenor of the findings preserves a critical distance. This self-conscious approach to my research design and data analysis is a method which Bryman and Burgess (1995) describe as "the hallmark of rigorous qualitative research."

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12etic= offering knowledge of universal ideas. emic = local or indigenous interpretations = generating data from people's viewpoint

*4.5.1 Reliability*

The reliability of the data extraction process is similar to the processing of food with the consequent loss of nutrients. A lot of 'goodness' is lost in the journey from the face-to-face interaction to the tape (non-verbal nuances); from the tape to transcription (loss of tone of voice/inflection/emphasis) and from the full transcript to final write-up with the consequent danger of distortion, bias or superficiality. With these insights in mind, efforts were made to ensure the conscientious recording of contributions, always taking into account the context within which they were expressed. Along with these factors, a sensitive awareness of job security and user litigation issues was also taken on board.

Buchanen et al (1988) argue that accounts are imperfect (they contain gaps and misunderstandings) and are frozen in time (respondents change their views) but insist that these situations do not "rule out the need for controlled, systematic, morally justifiable methods and scientific rigour." (ibid 1988:65)

However, I would argue that aiming for a level of reliability that would allow another similar study to generate the same range, diversity and explanatory association is not a practicable approach in the case of this study. Such replication presumes the existence of a static, objective social reality whereas, in reality, the health services experience constant organisational instability. The expectation of this kind of methodological reliability is a modernist criterion that emulates the research methods of the physical sciences. It is an approach that "goes against current postmodernist and poststructuralist trends within ethnography which foster the acceptance and celebration of diversity" Kelle (1997, Para 1.1).

A related issue is the chosen time frame which may be crucial in shaping empirical findings (Pettigrew 1985, 1990). When fieldwork was being undertaken, Crighton maternity unit was preparing to move to new premises as well as preparing to switch to community midwifery, whilst Bingham maternity unit was in the throes of merging with Warnick maternity unit. Since constant organisational change is an important feature of the development of the new public management initiative, the anxieties concerning these changes were incorporated into the research findings.

*4.5.2 Representativeness*

In this study, a precise statistical representation of health practitioners' views was not sought. Yet, it can be argued that the chosen sample is a relevant one and does 'represent' a spread of views across the various organisational tiers[13]. Pope and Mays (1995) reassure that statistical representativeneness is not a requirement when the purpose of the research is to understand social (or, in this case, clinical) processes. Interviewing a larger sample may or may not have resulted in a broader and deeper insight into practitioners' perspectives. At one extreme, each interview represented the person interviewed because individual health care practitioners hold a wide variety of experiences, expectations and perspectives. At the other extreme, however, they share a collective professional culture, the intensity of which is usually proportional to the extent of their geographical or professional proximity. Owing to the combined methodological design[14], I collected more data than this size of study can possibly handle and some relevant data will never be incorporated into the final synthesis. Clearly, this was a very fruitful area that yielded a vast amount of information and which, therefore, had to be drastically trimmed to fit the scale of this project.

Another reason why attempts to obtain a statistically representative sample would have been futile is that the two units had their distinct ways of negotiating access. In Crighton, the sample of consultant obstetricians was pre-selected but I was given free rein with regards to interviewing midwives and junior doctors. There was an element of opportunistic or 'snowball' sampling as names of potential participants at the various levels (junior doctors; clinical managers; senior and junior midwives), and across different occupational groups were suggested to me when I explained the nature of my study.

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[13] Organisational tiers. Corporate level: Non-clinical Trust personnel; Intermediate level: various operational and clinical managers holding assorted titles; clinical level: midwives, junior doctors and non-managing consultants.

14 See Section 4.4 which explains how the research design combines a research framework approach with a grounded theoretical approach.

Bingham used the opposite procedure. Midwives were pre-selected for me, whereas it was up to me to take the initiative and approach consultant-obstetricians for interviews. One obvious lapse was observed in Bingham. Nobody below team leader was selected by the clinical services manager to participate in the study. Eventually, after some persistence, I was permitted to interview one team midwife who was chosen for me. This procedure contrasts sharply with Crighton whereby it was up to the individual midwife and junior doctor to accept or refuse my invitation to participate. My impression is that in Bingham, midwives' time is more precisely organized and also management wanted to ensure that the public image of the unit was not going to be compromised or diluted by the possibility of negative feedback from busy team midwives.

Whilst this is essentially a Scottish study, there is no reason to suppose that the findings ought to be restricted to Scotland. Some of the key variables relating to quality and cash resources are more or less universal. What differs globally or nationally or from one Trust to another is the way health care practitioners combine their skills, experience and ethos within the confines of time and availability of funds. In addition, service user *choice* and *continuity of care* are policy issues that are applicable UK wide and beyond. The on-going structural and organizational changes within the NHS are also conducive to the generation of theory or concepts that have a correspondence across wider populations or public sector organisations.

### *4.5.3 Validity*

How can notions of validity be operationalised within an interpretative, as opposed to a positivist, research paradigm? Bowling (1997) defines *external* validity as the generalizbility of the research results from the 'sample' to the population of interest and McNulty and Ferlie (2000:78) refer to validity as the "extent to which it is safe to generalise from the case study site to other organisations." In qualitative studies, findings are expected to plausibly capture social reality or multiple social realities that may co-exist within one setting (ibid 2000).

Problems that may affect the *external* validity of this study are (i) the setting. Interviews took place in the participants' workplace. It is conceivable that the content of the participants' responses could have been somewhat different if held somewhere else, for example, in their home, at university or in some relaxed environment and (ii) the way in which participants were chosen. Following permission to access the two health care settings, the actual sample of participants was more or less negotiated.

*Internal* validity is "an important methodological concern possibly just as, if not more important, than reliability or external validity" (McNulty and Ferlie 2000: 87). Indeed, research data from only one organisation may provide high internal validity but low levels of external validity. In this study, internal validity was ensured by sending the analysis of my findings for face validation to the obstetric or midwifery managers, the 'gatekeepers', who provided me with access to each unit. This procedure ensured that conclusions about processes reported within the case-study site are well founded and that error, if any, has been reduced. A report on relevant findings was sent to the former directorate manager at Warnick, the clinical director at Bingham and the operational manager at Crighton. Apart from some minor adjustments, the returned comments[15] validated the findings. Issues of content validity were not raised and my analytical framework was not questioned.

### *4.5.4 Rigour*

It can be said that evidence is not the same as truth. One way of ensuring that findings are not too divorced from truth was by citing similar studies from secondary sources. Another method was to double-check unclear or unexpected issues with several participants. There was a deliberate attempt at cross-fertilisation[16] of fact and

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[15] One unit manager did not return any comments but did not object to the 'going ahead' with my findings.

16. An example of cross-fertilisation is when researcher states something like: "I was speaking to someone who said, 'If I want to find out what's happening, I can find out all about it because it's all published in journals'. On the other hand, others have said that they're very confused. How do you perceive the situation?"

opinion so that, without necessarily disclosing the identity of other participants, I explained to interviewees what their colleagues thought about a particular issue. This method often led to a discussion of issues raised.

Interviews can and probably ought to be seen as 'interventionist' causing participants to behave in certain ways or say things they would otherwise not have revealed. In-depth interviewing can inadvertently bring out people's hidden fears about the perceived objectives of the interview and hidden assumptions about their understanding of organisational methods and goals. Sometimes, the more a participant attempted to avoid disclosure, the more obvious concealed issues became. This insight was very useful during the pilot stage as it alerted me to the organisational landscape I was about to investigate.

The combination of a responsible and rigorous approach to this enquiry makes these findings a reliable source of information. If objectivity in the social sciences may be described as the sum total of subjective observation, action or behaviour, then an impartial and clear picture of trends and cultures within maternity care services does emerge. Undoubtedly, the degree of knowledge, skill and experience of the researcher inevitably influences the interpretation of what is heard, seen and read and ultimately what is and what is not included in the analysis. Neither researcher nor participant is immune to socio-political preconceptions and subjectivities when it comes to interpreting social health policy recommendations.

Official social health policies have a way of conferring an approved official language but despite wide usage by health care practitioners, the terminology does not guarantee a universal uniform understanding or application. Apart from individual and organisational differences in interpretation, social and health policies are often disguised by the power of a collective language that presupposes familiar and consistent social realities. Whilst the end product is inevitably shaped by the issues discussed above, the evidence presented in this thesis remains, in essence, a by-product of the participants' perspectives.

### *4.6 The participants*

All participants were informed of the objectives of the investigation and made aware from the outset of their right to withdraw from the research at any time and the option to reject the use of recording equipment. In order to preserve anonymity, pseudonyms have been used to replace the names of the maternity units and Trusts under study. In order to preserve the identity of participants, I have at times broken the link between direct quotes and the status of the individual who made the contribution except where the position of the participant was considered contextually vital. There were occasions when attempts to disguise the status of the obstetric or midwifery manager would have led to severely decontextualised evidence.

Interviews at Crighton stopped when findings reached saturation point – a stage recognizable by the indication that further participants are not essentially adding new data. As stated earlier, the quality of sampling was not entirely under my control, although I made a conscious effort to interview a diverse range of maternity care practitioners.

**Table 4.1 Number of Staff[17] and participants in Crighton and Bingham[18]**

| | **Crighton** | **Crighton participants** | **Bingham** | **Bingham participants** |
|---|---|---|---|---|
| Obstetricians | 18 | 3 | 4 | 2 |
| Registrars/Senior Registrars | 25 | 3 | 1 | - |
| Senior House Officers | 22 | 1 | 3 | - |
| Midwives | 323 | 17 | 102 | 9 |

In Crighton, preliminary meetings were also held with the Patient Services Director, the Principal Midwife/Professional Advisor, one Management Accountant, the

[17] Staff figures are approximate. These are partly disclosed by participants and partly drawn from ISD workforce statistics.

18 Full listings of Warnick, Bingham and Crighton participants can be found at the end of this chapter.

Divisional Financial Manager, and the Divisional General Manager of Craighill NHS Trust. Interviews at Bingham also included the Management Accountant for the directorate and the Deputy Director of Finance for Bellham NHS Trust.

Each participant came with his or her own individual experience and skill. More importantly, however, despite my brief, they had varied preconceptions of the ultimate purpose of this study and they all, consciously or unconsciously, came with a distinct and individual agenda. For example, it was not difficult to discern those midwives who habitually read midwifery journals from those who did not; those who perceived or used the interview as a political exercise from those who used it to sound off the strains and rewards of their profession; those who were suspicious, yet curious enough to go ahead, from those who welcomed the opportunity to make a serious and honest contribution. The way in which each participant responded to my questions, varied widely and alternative viewpoints were brought into the analysis rather than screened out.

Whilst I believe I remained faithful to the participants' expressed views and opinions, I did take their quotations away from their immediate context and into a wider theoretical framework. McNulty and Ferlie (2002:111) explain that

> "... accounts of social and organisational life produced by insiders and by outside researchers may be very different in nature (because) local practices are interpreted (by outside researchers) in the light of theory that is more general or of experience elsewhere."

In sorting and synthesising the participants' main concerns, my own biases would unavoidably come into play. These, however, are more to do with my particular field of vision rather than the deliberate promotion of a particular perspective. Reading background material prior to fieldwork assisted me to form an a priori viewpoint which I was open to re-consider. Indeed, there were many occasions where the impressions gained through textbooks and journals varied considerably from the realities disclosed by some participants.

At times, I uncovered matters I did not expect to find. On occasion, considerable interpersonal sensitivity was required. At one extreme, some participants were very

candid to the extent that they used the interview as an opportunity to sound off problems and grievances they had. At the other extreme, a number of participants were guarded and approached the interview with certain political preconceptions. Sometimes, because internal political issues were at stake, my questions were, at worst, treated with a certain amount of suspicion. Some, especially at Bingham, strained to convey firmly the best possible impression of the way maternity care is provided in their unit. Yet, it was an impression which was coupled with a restraining approach towards the accessibility and interviewing of team midwives (as opposed to their team leaders). Insights beyond the verbal can both hide and expose the nature of the organisational milieu. As Buchanan et al (1988:61) point out, "attempts (by participants) to protect or distort information can be used as data, as indicating areas of particular sensitivity which require explanation."

Treating diversity as a collective reality model, all transcriptions were given the same currency and the verbatim quotes were selected on the basis of their relevance to the theoretical framework. Ultimately, attitudes reflect realities that constantly change and intermingle amongst personnel in any given organization especially those subjected to the transforming influence of NPM.

### *4.7 Data Collection*

This enquiry uses multiple sources of data gathered from a number of sources:

- Government documents and statistical information
- Documented information about trusts and allied organisations
- Interviews with business and financial managers
- Interviews with consultant obstetricians/ paediatricians
- Interviews with junior doctors
- Interviews with senior midwives
- Interviews with staff and student midwives.

Secondary sources include various sets of data in the form of official information and reports about the maternity units under study. These comprise relevant Acts of

Parliament, White Papers, Scottish Office Reports, official documents about Trust mergers, national maternity care strategies, public consultation documents, conference papers, relevant statistical information from Information and Statistical Division (ISD) publications and a number of studies relevant to the maternity care setting.

The main sources of primary data were interview transcripts and fieldwork notes. I also interacted informally with midwives at conferences and public consultation meetings. These 'casual' informers included independent midwives, self-employed midwives, midwives who work at Birth Centres as well as hospital and community midwives. Informal and casual conversations sometimes revealed some of the ideas, beliefs and values of some clinicians. Disclosure of particular critical incidents usefully revealed the wider dynamics or yielded important information that sometimes served as a follow-up or a precursor to an interview.

This study is grounded in site-based fieldwork and therefore includes observations of research participants in their own workplaces. Attendance at hospital committee meetings or access to any relevant minutes was denied. The reasons given were (i) patient confidentiality in Bingham (ii) frequent structural and organizational changes causing confusion, uncertainty and discontinuity in Warnick and in Crighton. The refusal was very strong and categorical.

Initially very broad structural and organisational elements[19] were used to collect information, casting a big net and allowing information to flow freely. However, the reverse process was used when collating the data. Once the organisational features were established, issues not related to finance, choice and continuity were cast out. As with many qualitative traditions, interpretation of findings emerged during and after the systematic collection and analysis of empirical data. Although NPM-related issues set the conceptual periphery of the fieldwork, in many ways the research agenda kept evolving right through the analysis and comparison of the two units. Earlier assumptions were replaced by a dynamic and shifting interplay of primary

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[19] See Appendix 1

and secondary sources and, significantly, new insights emerged when evaluating the findings from each site.

The evidence is presented as a combination of: *soft data* - documentary analysis of the secondary sources and ethnographic accounts; and *hard data* - selective use of facts and figures from official statistics, financial reports and other quantitative documentation, bringing about a triangulation of quantitative data obtained from secondary sources with qualitative empirical evidence collected during fieldwork. Although it was a complex task to manage and analyse these sources of data, I tried to maintain a structured approach and a transparent method throughout. The process of abstraction and synthesis of primary sources was done using the manual method, 'cut and paste' approach. During the process of analysing and synthesising the ethnographic data, the option of using software packages was considered but not adopted.

### *4.8 Qualitative software packages*

According to Barry (1998), qualitative software packages can benefit and enrich the analysis process. Indeed, the original intention was to use software packages with the prospect of assisting me to codify and control the data that were emerging. However, the interviews were completed in clusters and subsequently transcribed in clusters. There was a tendency to simultaneously transcribe and analyse the taped interviews in clusters as well. Once a batch of interviews had gone through this process, emergent themes became evident and the need for simulated processing aids became increasingly redundant. I did however investigate the potential of several packages and found them, in general, to be more suited to projects involving a larger number of interviews yielding larger amounts of data.

Ultimately software packages are in danger of manipulating the text without any reference to the spirit, tone and inflexion of the words spoken, something which was taken into account when transcribing. There was a risk that dependence on such a package would de-contextualise themes or would atomise the issues or themes in question and forego the global picture conveyed by the participants. Artificial

intelligence is liable to distort a badly worded, albeit a significant, response and possibly over-structure an unimportant one.

Putting aside various unavoidable limitations, when the analyst is also the interviewer as well as the transcriber and codifier, as is the case here, the chances of a finer synthesis are maximized.

# The Participants

## Bingham Maternity Unit

### *A. Practitioners*

2 Consultants: (clinical director; consultant obstetrician)

4 Senior Midwives: (clinical co-ordinator; clinical services manager; core midwife; special care baby unit G grade[20] sister)

3 Team Leaders: (all trained in general nursing and midwifery)

1 Core Midwife

1 Team midwife

### *B Non-practitioners*

Deputy director of finance [Bellham NHS Trust]

Management accountant for directorate [Bellham NHS Trust]

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[20] See Appendix 3 for a list of National Grades for Midwives

## Warnick Maternity Unit

The Directorate Manager of Women and Children[21] and Surgical Services and since July 2000, the Directorate Manager of Surgical Services for the whole of Bellham (the merged Bingham and Warnick maternity units). This participant is not a health practitioner.

The Senior Midwifery Manager at Warnick - since July 2000 - the Nurse Manager for Women and Children for the whole of the Bellham region.

One obstetric gynaecologist

One paediatrician

One senior midwife

[21] Women and Children Services incorporates paediatrics, Special care and Intensive Care babies, obstetrics, obstetrics and gynaecology and gynaercology out-patients.

## Crighton Maternity Unit

### *A. Preliminary meetings held with:*

1. Divisional General Manager

2. Divisional Financial Manager

3. One management accountant

4. Principal Midwife - Professional Advisor

5. Patient Services Director

6. Operational manager (followed later by an in-depth face to face interview)

### *B. 25 face-to-face in-depth interviews with:*

3 obstetric/ gynaecological consultants

2 senior registrars

1 registrar

1 senior house officer

1 medical student

5 senior midwives/clinical managers

5 F grade midwives [two belonging to NDU]

7 E grade midwives

# Chapter five

## Site one: Bingham Maternity Unit

### *5.1 Introduction*

The first section of this chapter outlines the organisational framework at Bingham Maternity Unit. In particular, it looks into its midwifery system in some detail and examines how such a practice assists in promoting choice and continuity of care for the service user. The second section considers the impact of economic rationalism on team midwifery, examining, in particular, the cost consciousness culture, staffing levels, skills, remuneration and other aspects of the costing process. The final section brings together the human and infra-structural elements such as the degree and range of inter-organisational communication and inter-professional cohesion and sets them against the limitations imposed by the NPM regime.

### *5.2 The organisational framework at Bingham*

In previous decades maternity care concerns were focused largely on infant and maternal mortality, rather than policy issues such as choice of treatment and continuity of care. Whilst the latter may have always been desirable features from the users' viewpoint, they have only begun to surface into the political arena in recent years as the prominence of death and morbidity in childbirth began to subside.

### *5.2.1 Profile - Bingham maternity unit*

Bingham is a consultant unit attached to a large District General Hospital serving a population of around 144,320 (GRO 2003), residing in a large town and in a number of neighbouring rural areas. In general, the district it serves is renowned for a moderately high percentage of low socio-economic neighbourhoods. In 1994 team midwifery was introduced to integrate community, GP and hospital services thus offering a more integrated maternity service with a view to improving continuity of care for women. It was expected that team midwifery would not only improve the quality of care and increase midwives' job satisfaction but that it would not prove to be more expensive to run than the traditional fragmented system.

The team midwifery system consists of seven teams comprising 7 to 7.5 WTE midwives. Seven team leaders act as coordinators for each of the teams. Each team provides midwifery services to a given geographical area and runs its own parent education classes and breast-feeding workshops. The unit also employs a small number of core (hospital-based) midwives in the ante and postnatal clinics and delivery suites. At the time of writing, Bingham was in the process of merging with Warnick. Anxieties about the future relate to (i) the upheaval relating to the physical expansion of the unit and (ii) the complex political problems relating to the merging of two distinct maternity systems.

### *5.2.2 The merger*

The plan by Bellham Trust is to go ahead with a single enlarged maternity unit that is intended to cover the populations of both Bingham and Warnick[1]. At present, the two maternity units situated in separate hospitals, deliver different systems of midwifery and hence distinct styles of maternity care. For example, they differ in the extent to which they are able to provide choice, continuity of care and carer and the way in which they enable or restrict midwives to use the full range of midwifery skills. One participant felt

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[1] See Appendix 6 for a fuller account of the merger

that economic rationalism will triumph over the provision of quality maternity care when the merger takes place.

> "What's cheap and probably works well for the women, I think that's how we will end up at the end of the day. And let's face it, if team midwifery was too expensive, it would be out of the window" (team leader).

*5.2.3 The organisation of team midwifery at Bingham*

Midwives are qualified to provide care throughout pregnancy, labour, and the puerperium and it is their responsibility to recognise those signs of abnormality which require referral to medical staff. Midwives are expected to provide women with advice, information, and emotional support, from the early stages of pregnancy to the end of the post-natal period. Policies for the health services have at times facilitated the fulfillment of this role. At other times, and particularly in recent decades health-care policies, such as the trend towards obstetricalisation, have hindered and obstructed the full use of midwifery skills and knowledge (Garcia et al. 1990). A number of other studies (Robinson at al. 1983, Robinson, 1985) show that many midwives are not able to exercise this clinical judgment about the management of care.

In order to overcome fragmentation of care, improve satisfaction and enhance continuity of care four systems of midwifery care exist:

a) Individual care plans where women are given the opportunity to be partners in their own care

b) Patient allocation where midwives are allocated a number of mothers to whom they will provide care

c) Team midwifery where a team of midwives provides care in the antenatal, intra natal and post natal period and so ensure continuity of care

d) DOMINO schemes introduced in the 1960's as a means of offering an alternative to low risk women who wished to deliver at home but in the interest of safety were encouraged to deliver in hospital.

Different combination of these maternity needs and service modes can be found in various maternity units up and down the country. Bingham operates a team midwifery system.

Team midwifery is hard to define because the concept of a 'team' may indicate anything along a continuum of loose to very tight formations. A report, which attempts to map team midwifery, indicates:

> "Despite a comprehensive literature search, detailed analysis of the survey questionnaire and discussions with many managers and midwives, no clear definition has emerged for the term 'team midwifery'" (Wright, A. et al. 1993).

The authors of this report go on to outline three types of teams. Level one teams consist of no more than six midwives ensuring that 50% or more of women are delivered by a midwife known to them. Level three teams consist of fifteen or more midwives where the proportion of women delivered by a midwife known to her is not known. The term 'team' has a wide open definition and can be applied to a hospital-based team or to a community based team or it can be applied to a more structured system of midwifery such as the one in Bingham. Using the Wright et al. (1993) typology, team midwifery at Bingham would more or less belong to level two category: i. the team consists of seven to fifteen[2] midwives; ii. each team has a defined case load which provides total care in hospital and the community; and iii. at least 50 % of women are delivered by a midwife known to them.

Bingham Royal Infirmary uses the named midwife concept. The *Rainbow Team Midwifery* system, set up in 1996,[3] involves the formation of seven teams of midwives covering seven geographical areas. Each team has a maximum of nine midwives who deliver holistic care within an integrated service with a caseload of 250 - 300 deliveries

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[2] In the case of Bingham, no team has more than nine midwives.

[3] Team midwifery was introduced in 1994 but it took two years to establish and to bring about the major cultural and organisational changes.

per year. Core midwives, who provide support to the teams, service the inpatient areas within the hospital. In order to acquire comprehensive midwifery skills, which integrate the community, GP and hospital services, midwives are expected to gain experience in ante, intra, postpartum, community and other specialities.

Some of the prominent features of team midwifery at Bingham are autonomy, partnership, and devolved power. Putting into practice the vision of those who developed team midwifery in Bingham has, in many respects, proved beneficial:

> " I think I've got a lot of confidence from being a team midwife. To me working in this system is a lot different to how we worked before." (Team Leader)

The notion of devolved power was appreciated by another midwife:

> "The relaxed atmosphere has now become quite incredible because they've taken away the hierarchy" (team leader).

Balancing satisfactory arrangements between service user and practitioner is an important vital consideration that the management team at Bingham have earnestly taken into account.

> "It's made our midwives quite sought after because if you go for a job somewhere after being qualified two years, you can offer holistic care and community care. You're a valuable asset. You are an asset to an employer and you're a valuable asset to the women because you can answer all their questions. So it makes our midwives into better midwives" (team leader).

The team midwife's work is varied and includes GP clinics, hospital ante natal ward duties, community visits, parent craft sessions, day and night ward duties, post natal visits and post natal ward duties. On top of this, there is an increasing burden of clerical work. All team members work a ten-and-a-half hour shift. Although a team may decide for itself when each shift starts and ends, each team ensures that three midwives are

working three overlapping shifts within a 24-hour period[4]. Instead of having on-call intervals, midwives are expected to complete a certain number of night shifts each month. The proportion of time spent in hospital and the community might vary from team to team and from midwife to midwife depending on factors such as staff absence and whether the midwife works part or full time. One participant explained that her time was split about 60% in the hospital and about 40% in the community.

Within each team, the number of midwives and their skill mix varies, since each team decides on its own style of care within an overall team midwifery concept. The total number of hours worked, individual lifestyles or domestic commitments all come into play in shaping the pattern of shift work within each team. When a team member is off, the rest of the team may have to work longer shifts, possibly without any overlaps, until she returns or until she is replaced. Different approaches to team midwifery usually hinge on getting the balance right between (i) workplace and domestic responsibilities and (ii) a professional and a flexible approach towards users. One participant suggested that the younger or newer midwife is more likely to be flexible. Overall, however, a "good and supportive team leader accounts for a lot" in terms of co-ordinating team members with different skills mixes and approaches.

### *5.2.4 The philosophy behind Bingham's team midwifery*

Studies have shown that the majority of women want continuity of care, reasonable access to information, support, communication, less routine intervention, choice, a welcoming environment, better and more equal relationships with doctors and midwives, and as little medical/technical intervention as is safe for them and their babies. Indeed lack of information and inadequate communication in the midst of high technological orientation has made it increasingly difficult for women to retain and exercise their

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[4] The shifts are: 7.00 - 17.30; 11.00 - 21.30 and 21.00 - 7.30

rights to choose and control over where and how they give birth to their babies (Edinburgh Health Council, 1991).

The traditional system provides a fragmented service with midwives posted in either the ante or postnatal clinics or labour ward with only a small minority working as community midwives.[5] Within this system, midwives do not get opportunities to interact, especially if the labour ward and clinics are situated on different floor levels. In contrast, the formation of teams in Bingham has broken down these old barriers.

> "Now everybody values everybody else's input (and) everybody draws on everybody's resources and that can only be to the benefit of the women because they're getting the best all round care" (Clinical Services Manager).

Bingham's team concept adopts a holistic outlook towards maternity care:

> "Instead of looking at a part of the service, we look at the whole service and how it impacts on the family" (Clinical Coordinator).

This holistic approach also applies to the comprehensive skills required by the team midwife. In some respects, team midwifery seems to mitigate against excessive obstetric input.

> "We would hope that there would be less medical intervention, as far as possible (and that) our caesarean section rate is one of the lowest in the country[6]. The successful home birth rate has risen since the teams came into place because the midwives who are going out to the home confinements are experienced in labour whereas when you only have community midwives, their experience in labour ward might have been 15/20 years ago. They might only have done two deliveries in that time" (team midwife).

Identifying with a particular team has also helped service user empowerment giving

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[5] Community midwives only work in the community and away from the hospital. They do not provide intrapartum care as do integrated midwives.

[6] However, another participant observed that the caesarean section rate has nothing to do with midwifery teams because it was the lowest in the country before teams were introduced and is now no longer the lowest, though it is amongst the lowest.

women a secure sense of identity within an otherwise large and faceless institution.

> "From the point of view of the women, it's less stressful because they get an answer quicker from the midwives in the teams."

One theme underlying the team concept is identity:

> "We tend to find that women feel an identity. If you say to them when they book, you belong to the red team and these are the midwives in the red team, and if you have any problems during your pregnancy, just phone up and ask to speak to somebody in the red team, they have an identity and even if they have never met you, you belong to their team."

Indeed attachment to team identity can sometimes mean that:

> "We do get to know them quite well. And to be fair there's quite a few of them who have come back in pregnant on the team and they know us from before."

It was alleged that team midwifery not only empowers service users but frees up midwives as well.

> "The positive things are the flexibility and the off-duty roster allows you to have spells off if you need something or if somebody has a problem with child care, you've only got your team to sort it out with. You haven't got a large organisation to sort it out with. Holidays are worked out within the team, so there's nine of you working out your holidays per year. Whereas before it was like the whole ward."

### *5.2.5. The impact of the Cumberledge Report- the experience of change in maternity care provision at Bingham*

In order to obtain maximum continuity of care at the lowest cost possible, the team midwifery model which replaced the traditional fragmented midwifery model included both newly qualified midwives and experienced ones to work together within the community as well as within the hospital, ensuring all midwifery skills are practised within an integrated system of care. This means that midwives within a team are interchangeable providing, primarily, continuity of care and possibly, for some but not

all users, continuity of carer[7].

The participants in this study reported at least four key changes as a result of implementing the Cumberledge Report.

*Firstly*, there has been a change in inter-professional relationships. As one consultant put it,

> "Cumberledge changed doctors-knows-best attitude amongst midwives" (consultant).

This was a view shared by a midwife:

> "When I first started it was more medically orientated. We really just carried out the doctor's instructions - more or less. I mean looking after a patient in labour hasn't changed terribly much, but *we* have. We do a lot more things now than we ever used to do. We're taking the work out of the junior doctors' job" (team leader).

*Secondly,* service user expectations have been raised:

> "Women are now aware of what they're entitled to, and what to expect from midwifery services and they're a lot more informed when they come to book with you" (team midwife).

A consultant also added that a free book, 'Ready, Steady, Baby', and various pamphlets, which explain pre-natal screening and how labour is monitored, are now readily available to the service user. Service user needs are best served by,

> "providing more information from whatever source, giving more verbal and written information about investigations and the reasons for them, giving figures for various risks when asked or when necessary, mentioning possible side effects, say in relation to induction" (consultant obstetrician).

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[7] Continuity of care refers to care provided by known health care practitioners. Continuity of carer refers to treatment by the same carer throughout.

*Thirdly,* Cumberledge also seems to have changed the relationship between doctor and service user. This includes a trend towards more open discussion between them as well as an opportunity for the user to articulate their choice or choices[8].

> "The culture now is to tell the patients everything, you offer them everything and you discuss everything with them. They expect more from us. They expect to be involved far more and they expect to be given a lot more choices than they ever did before" (senior midwife).

This participant felt that the media is partly responsible for "hyping up" issues of service user involvement in the clinical process. Owing to an increased flow of information, service users' requests for Caesarean sections have increased.

One midwife admitted that at times some of the questions posed by service users have stretched health care practitioners' knowledge or challenged it.

> "It's a thing of the past where a doctor is seen as a wee god up there and I don't think that's the case now. I think more people now will question the doctor than they used to. There will still be some people who won't question what the doctor says to them" (senior midwife).

This view is supported by Bertilsson (1994):

> "Whatever the future will be regarding the current moves on 'accountability' of both scientific and professional practices, the bases of professional powers are certainly coming under increasing attack due to the rise of various citizens' organisations and social movements. The results of these moves among groups of citizens and clients are likely to change the previous asymmetry and (unquestioned) trust that earlier characterised relations between professional practitioners and their clients/patients."

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[8] User choice comes at many levels and at different stages throughout the antenatal, intrapartum and postnatal episodes. Choices are dependent on a number of factors. This study focuses on extenuating factors that influence or restrict the number and kind of choice rather than listing all the possible options for service users.

Increasingly, more service users request to be furnished with "good reasons" for their diagnosis and treatments.

The overall impression gained, however, is that, although the service user - health practitioner relationship has changed, the parameters of choice, as will be seen later, are still largely institutionally designated.

*Fourthly,* the role and status of the midwife has changed. [9] Whilst a participant reported that the midwife-practitioner has become more autonomous since Cumberledge (at least this seems to be the case in Bingham), she also described the changes she experienced as a midwife since 1968.

> "I've been on this job so long, really, things are just going in a complete circle. I mean when I came into this type of team midwifery led - it was gospel, then it all fell flat and we started to look after patients nine till five. Everybody had to come in (into hospital) right through the seventies. Then the women themselves started to rebel against it" (senior midwife).

The impact of the Cumberledge report depends on a combination of factors, for example, the hospital culture[10], the extent to which individual practitioners are receptive to service user requests and the breadth of their knowledge base which influences the extent to which they direct or are prepared to be directed by service users' choices. The sections which follow will examine the impact of staffing level and the organisational structure which can also shape service users' experiences, particularly during the intrapartum episode.

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[9] For an account of how the role of the midwife has changed over the years, see Appendix 5: The development of Maternity Care

[10] As will be seen in the chapter that follows, not all maternity units are prepared or disposed to respond to the spirit of the Cumberledge Report.

### *5.2.6 Some factors impinging on service user choice*

According to midwives' reports, the percentage of women expressing their choice is usually much higher than the percentage actually having their choice fulfilled. Reporting on a study of Scottish midwives' attitudes to changes that have occurred in the maternity services in response to new government policy, Hillan (1999) found that 30% of midwives agreed that women have little say in their maternity care. There are a number of clinical and non-clinical reasons for this state of affairs. Some of the sentiments and ideals about service user *choice* underlining *Changing Childbirth* and similar reports contrast quite sharply with the pragmatism of a graphic comment coming from a senior midwife.

> "Most of the patients (past their date) ... are climbing the walls ready to be induced and most patients ... will be looking for induction before term plus 14 because they just can't stand it any more" (senior midwife).

Even situations where women have already planned to turn down medical intervention can be reversed during the critical intrapartum episode.

Choice is an attribute accorded to the one who is able to choose. During the intrapartum period, states of distress can easily break down service user control and choice becomes merely an impractical ideal. At the same time, one participant pointed out that the extent to which a pregnant woman is prepared to wait rather than be induced is usually related to her background.

> "Patients who read every pregnancy book know what the risks of being induced too early are (feel strongly against) induction and emergency section for whatever reason. These are the ones who would ask for less medical intervention towards the end of their pregnancy" (team leader).

The educational background and/or the depth of knowledge of the service user can be key to her preparedness for the crucial delivery episode optimising her chances of exercising appropriate choice. Similarly opting for Complementary and Alternative Medicine (CAM),

> "depends on the social standing and social class of the patient because if they've read anything about it, because if they've known people involved in it, I think it's more likely to be people from the higher social classes than lower social classes."

Another midwife pointed out,

> "You find the more intelligent, more educated person are the people that want everything to be natural with no intervention at all and that includes any analgesia whereas other people, first contraction and - 'I want this, I want that.' Probably about one in ten - maybe one in fifteen (prefer no intervention)."

Expectations from maternity care services are apt to differ quite dramatically. Where midwives are faced with "very highly motivated women NCT / AIMS[11] background," they get many requests.

Pregnant women are not a homogenous group. As Allen et al. (1997:108) explain: "The interplay of personal, family, social and organisational factors produced an interesting diversity which highlights the challenge in developing and tailoring services to meet women's needs." In Allen's study, when similar preferences for place of delivery were expressed, their reasons for doing so were not necessarily the same. Women have different experiences of the past and different expectations of the future so their choices can also be influenced by previous positive or negative experiences. Other studies, such as the one by Reid (1994:196), suggest that the "range of options during (her) childbirth; ... is affected by the age of the woman, her parity, her social class, her ethnicity and of course trends and fashions which shape maternity care as they do other aspects of life." McIntosh (1989) found that many of the women from working class backgrounds reported positive attitudes towards technology and intervention which they found reassuring, whilst another study by Oakley, (1979) suggests that middle-class women are

[11] NCT (National Childbirth Trust) and AIMS (Association for Improvements in the Maternity Services) aim to provide support and information about maternity care.

interested in having a positive birth experience and hope to have as little intervention as possible.

Whilst extraneous factors discussed above do have an impact on the exercise of choice, according to one participant "better patient choice was the main driver" for the setting up of teams.

> "I think nowadays we tend to listen more to the patient and try, where at all possible, to abide by her wishes" (core midwife).

However, in general, findings from this study suggest that service users need to show some determination before they can see their choices put into practice.

### *5.3 Maternity care and economic rationalism: implementing Cumberledge*

The setting up of team midwifery at Bingham was clearly shaped by Cumberledge and a number of similar reports flooding maternity care units urging them, inter alia, to allow service users to exercise choice and to devise a system or systems to ensure some degree of continuity of care. Yet, Cumberledge arrived in the midst of new managerialist changes that attempted, iner alia, to drive costs down and to hold key personnel accountable for budget management. Ultimately, therefore, cost considerations defined staffing skills and staffing levels. One consultant informed,

> "There was no pump priming for the team system at Bingham, unlike the case elsewhere, and no savings were anticipated. Indeed, it should have cost more than the older set up, but when the teams were set up, core staff were pared to the bone initially to come in under the existing budget allocation. It (the setting up of midwifery teams) was extremely hard to even make them cost neutral, and that was essential to have approval from the Bellham[12] Trust."

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[12] In order to preserve anonymity, the name of the Trust has been changed.

The clinical services manager explained the financial side of setting up team midwifery at Bingham.

> "As part of implementing team midwifery, I looked at a new pay structure for midwives. Over a period of years I have reduced the number of high grades as people retired. There were something like four nursing officers here ten years ago and when a nursing officer left, I replaced them with one and a half to two practicing midwives. So, I increased the manpower but reduced the grades. I think that that's one of the big problems in most units up and down the country. It is the number of very highly graded people. Now that's debatable because you have to have some kind of structure for midwives. But if you expect to give women choice and provide continuity of care, you have got to look at everything and I felt at the time, and I'm getting there gradually, what I needed in terms of senior midwives was seven team leaders, one person to manage labour ward, a clinical specialist and a senior person in the antenatal/postnatal area. And I can produce gradually each of the G grades that I had. Over the years, I gradually increased my manpower and made some efficiency savings. So there are ways of doing it."

This arrangement echoes some of Pusey's observations about the way careers are redefined as a means to an end and how remuneration is set by an external market and therefore valued in cash terms.

> "Staff mobility has been redefined as 'human resource management': an application that is, of course, simply a micro-technical extension of the same economic rationalism. The movement and assignment of staff is then driven by the assumption that each public servant is no more than an individual bag of skills in a freely moveable bag of skin" (Pusey 1991:183).

When I asked the Deputy Director of Finance at Bellham Trust whether the issues of continuity of care and service user choice ever came into the picture when making financial decisions, she required clarification as to what I meant. Although the two concepts were clearly not new to her, it was evident that they have little or no bearing on financial decisions taken at board level. When I spoke to the directorate management accountant about the same issue, he proclaimed ironically "that would be at a higher level than me" and later moved on to explain that,

> "choice and continuity are driven by clinicians. They are the experts within the hospital. Clinicians should be the drivers for change."

In general, managers, administrators, and various finance personnel hold a global perspective about maternity care finance that does not give prominence to social health policies such as the ones recommended by Cumberledge. Finance policy documents are all too often far removed from clinical realities except, perhaps, for those in very senior posts who may have contributed to the policy document[13]. Whilst it is up to health care practitioners to put forward a case for increased funding, some clinicians revealed a fragmented knowledge of official documents and their understanding was underlined by various rumours. These gaps in understanding along with the multiplicity of viewpoints that operate amongst NHS personnel became increasingly evident with each completed interview.

Bingham's management team claim that, through their team midwifery system, they are adequately satisfying service user choice and continuity as well as the cost limitations set by the Trust. Yet, both service user choice and continuity of care are loaded concepts. And whilst there seems to be no universal benchmark to assess the extent to which practitioners can, should, and are putting these precepts into practice, there is no doubt that Bingham's team midwifery system provides better service user contact compared to the traditional fragmented approach. Only one participant disagreed with the rest that service users are now more satisfied with the level of choice and continuity offered. Otherwise, all the other participants at all levels of the hierarchy affirmed this claim categorically and consistently. The dissenting participant, who is not a team midwife, pointed out that team midwives are not always able to cope with the workload, and are sometimes pressured to cut corners, such as phoning instead of visiting the service user.

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[13] This is a reference to official documents proposing financial and structural changes. In a process that I call 'cross-fertilisation of issues', I discovered that various participants in key posts hold a very different understanding of the purpose of such documents.

*5.3.1 Maternity care and economic rationalism*

In the recent past, the provision of Maternity Care, like other aspects of health care, has had to undergo the revolution of becoming a service run on 'business' lines where such terms as cost-curtailment, cost-accounting and cost-effectiveness have become part of the system. Yet an increase in malpractice suits and the consequent expenses involved are liable to increase the tension between the business manager's concerns (which are likely to concern the aggregate client population) and the welfare of the individual patient.

Putting service user choice aside, the choice of treatment decided on by the health care practitioner can be based on various other factors such as, efforts to increase productivity (irrespective of waiting lists and urgency of treatment required) in order to satisfy the NHS Efficiency Index; or to satisfy policies which are politically more convenient in the short-term but do not bear on the fundamental issues; or to test out new technologies from drugs to diagnostic testing to information technology. Within the maternity care environment, the testing out of new technologies is often likely to influence the practitioner's choice of treatment. Timesaving medical and technological advances speed up increasingly exacting surgical operations which may not be error-proof but are instantaneous and largely efficient.

In this site, economic rationalism shapes both the quantity and quality of health practitioners recruited. Budgets have becomes tighter, cost consciousness has become widespread and, ironically, though not unexpectedly, litigation costs have increased and so has the cost of monitoring the finance system. Evidence collected from midwives and consultant obstetricians suggests that economic rationalism impacts on maternity care in a number of ways. *First*, despite its obvious advantages, the team midwifery system operates within a strictly limited budget resulting in stretched human resources effectively resulting in more work for fewer members of staff.

> "And of course we're all to do more and more - to take on more and more. We've taken over junior doctors' things" (team leader).

On being asked whether things can seriously go wrong because of the present low staffing levels, one midwife replied, "Oh yes, I think all hospitals have that problem". Unfortunately, cuts in staff numbers is often the standard short term economic solution.[14] In the baby intensive care unit, where there is no operation of teams, staff absence can be seriously stressful.

> "Of course it means everybody changing off duty and perhaps they've got arrangements made and you feel awful asking people to change their plans; and then sometimes you might be forced into changing your own plans and if it happens too often, people will feel a bit resentful and therefore it is stressful."

One obvious way for budget holders to save cash is by reducing human resources, which ultimately means reducing a service. Part of this is achieved by not filling vacancies. The directorate management accountant for Bellham Trust explained that in order to resolve problems of over-spending some clinical ward managers apply the 'vacancy factor.' This effectively means that when one member of staff leaves, filling the post is delayed over an indefinite period of time depending on the manager's discretion thus saving on human resource costs. The clinical director who is in a position to recruit and let go of staff admits that,

> "If you want a cheaper service, you have to have less staff. If you want a better service, you need more staff or better-trained staff. You certainly can't do with less if quality is an issue."

The clinical director did not seem unduly perturbed by this strained situation, accepting the primacy of economistic dictates. Pusey (1991:154) describes similar instances of rationalisation within the public sector.

> "Those who drive the process of rationalisation believe in it and deploy it very powerfully as an evaluative framework that throws a difficult onus of justification on anyone who seeks to oppose them with defenses premised on

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[14] The NHS Plan (July 2001) promises an increase of 7,500 more consultants, 20,000 extra nurses (unspecified) for the 21st century.

> social needs or on values such as equity, compassion, common sense, wisdom, courage, and integrity. "

In a climate of 'economism' where all costs have to be accounted for and economic projections more or less adhered to, human resources and training are often viewed in terms of commodities rather than resources which can bring about long term economic benefits. Irrespective of the dissatisfaction expressed elsewhere within the unit, the clinical director maintained that Bingham is largely successful both in terms of flexibility for the midwives and in terms of budgetary containment.

> "We're fairly flexible within our system and we manage, on the whole, to accommodate most of what is requested with only a small tweak to budgets. Flexibility of our shift patterns, the flexibility of our working doesn't impose too much of a burden" (Clinical Director).

Indeed, the economic success of team midwifery means,

> "We don't have to employ any more staff to do our on-calls for our water birth or for home deliveries" (Clinical Services Manager).

The overall impression conveyed to me by Bingham's managers is that team midwifery gives more choice and more continuity at no extra cost largely because the midwife's time is used more efficiently. This situation is recognised by those who are managed.

> "I think you are working more for less really because you are covering many areas. I think they are getting better value for money from us" (team midwife).

*Second*, economic rationalism has brought about a cost consciousness culture. Cost awareness amongst clinicians has become sharper. "I tend now to look at the cost of things more than I did before." Moreover, for those who are in a senior position, cost awareness is usually translated into action.

> "I must admit I am very conscious of all the tests we send on patients. If it's two tests to determine exactly the same thing, I don't see any point in sending them off at the same time."

The pressure to put cost consciousness into practice has meant some fairly drastic re-

thinking about routine matters.

> "When I first came here[15], every patient that came to the ward antenatally, every admission used to have their specimen sent along to the lab. All that stopped now. There is no benefit in sending them but it was the practice and everybody had them sent. And it has stopped. Now, I wouldn't say that we detect less urinary infections now than we did before. It was a very expensive practice sending off urine for every patient."

None of the anecdotal evidence indicated that the new cost consciousness culture, particularly amongst non-budget holders, was compromising the standards of care. Morrison (2000) points out however, that since hospital practitioners are expected to outline choices to the service user, such practices can be jeopardised by inflexible financial systems. "Under such circumstances, can the doctor give the patient an 'independent' opinion that truly reflects the 'best interests of the patient'" (ibid 2000:208)?

The clinical co-ordinator of Obstetrics, Gynaecology and Paediatrics at Bingham explained how thousands were saved simply by purchasing non-sterile sanitary towels as opposed to the sterile ones which used to be bought. She also pointed out how staff are encouraged to be more cost conscious and to look into reasons why expenditure may have gone up from month to month. Sending staff on *Finance Awareness Days* which are seminars on NHS finance policy and practice is another effective way of instilling cost consciousness. Over the years, the unit has been transformed into a system whose operators are very conscious of their spending with a budget holding team who apply firm expenditure controls.

Two participants describe how control over resources has changed over the years.

> "When I first started in maternity services, we didn't actually have much regard for what we were using. It was always there. You used as much as you wanted and when you wanted without much regard to it. Now you

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[15] This participant has been working at Bingham since the early 1980's.

> question why you're actually using something. Is it relevant to the patient care? Is it going to improve patient care? That kind of thing. Before maybe we didn't look upon it in that light."

But according to a team leader, with almost forty years experience in the NHS, the attitude towards the perceived use and abuse of resources has been cyclical:

> "It was 1963 when I started and you had to be quite careful over repaired things - repaired clocks and this sort of thing. And then it got exactly the opposite when all the disposable stuff came in and everybody got quite lackadaisical. And, I think you did get quite extravagant and wasteful with these materials. But now, you think more about it because it is more expensive and we have to be more careful now. Now, we have senior staff meetings (and) cost for this and that, you know, so that you're aware."

Another feature, which has helped to reduce overall costs, is the drastic cut in inpatient stays. According to the clinical co-ordinator, the average inpatient stay during the whole period of pregnancy in Bingham is 3.3 days whereas inpatient stays in units such as the one in Warnick are considerably longer. A quick throughput of women results in immediate cost savings and financial savings for hospitals.

Length of hospital stays does not necessarily reflect the degree of care provided. For some women a short stay may indicate a quick and satisfactory outcome resulting from effective care. Other women are not satisfied with their care in hospital and request to leave early (Allen et al. 1997). In Bingham, women prefer short hospital stays, which ultimately means a reduction in costs. The informant, however, insisted that care considerations are focused entirely on the needs of the mother and her baby. Such matters take priority over cost considerations, such as returning home early when it is deemed clinically risky.

One participant outlined her awareness of waste and the earnest attempt to avoid squandering resources:

> "We have to be more cost conscious than we used to be in the past ... for example, our theatre isn't utilised the way it should be utilised - and sometimes if we're having emergency caesarean section, we've got it all set

> up in there and then the anaesthetist says 'no, we want it in the main theatre' ... so that pack has already been opened and then you open another pack for the other theatre" (core midwife).

Other steps taken include attempts to make personnel more aware of the cost of stock items.

> "Although it's something that could be done by Nursing Auxiliaries, the teams now work on a two monthly rota so that once every 14 months, each team is responsible for stocking and maintaining all the equipment that is needed to go out into the community for doing care for mothers and babies. So now, they have to know what's going in - to know where it comes from. They have to check it off when it comes back and they see how much things cost. So it's a way of giving them a bit of insight into (costs)" (team leader).

Cost awareness seems to have had some practical results.

> "The girls have come up with ideas. I think we used to throw away all the disposable nappies if they've been in the cot but now we spoke to Infection Control and that's not absolutely necessarily. If they haven't been used, we can use them again unless the baby had a serious infection or rash." (SBCU G Grade sister)

The senior midwife went on to explain how other cost savings have been made.

> "I wouldn't advocate opening packs either because I've seen it happening in the past: you think you're going to get a premature baby through and unfortunately it dies in labour ward and you have opened all the drips and things and that's very wasteful."

Another suggestion for saving costs is to use a sterile towel, which may be laundered and re-used, instead of disposable paper towels for drying hands because research shows that "there's no higher risk of infection." The participant went on to explain how midwives get together to figure out what they could change perhaps by looking at clinical practice in other hospitals or take on ideas read in a relevant article. Cost cutting policies and procedures have been initiated by midwives usually after conferring with the relevant consultant.

With all these cost cutting measures, how easy or difficult is it for a consultant to obtain

new equipment currently needed, for example, to detect asphyxia in labour? The participant accepted that there had been a change in the spending culture, adding,

> "I don't see any problems getting it. But, maybe we're quite an efficient department. I don't think we're terribly wasteful. We're not extravagant" (Clinical Director).

*Third,* economic rationalism does not sit happily with the current surge in litigious action. A squeeze on staff numbers has its consequences. Eddy (2000) argues that doctors need to provide the kind of service that takes priority over the numbers the NHS can 'afford' to employ because stressful clinical environments could result in serious error. In the same article, Eddy points out, "the Litigation Authority for the NHS showed that until 1 April 1999, some £290 million was paid out on medical litigation for obstetric cases" (2000:204). In support of this figure, Toynbee (1999) indicates that "costs for litigation in the NHS has now reached £1.7 billion a year, or that £1 in every £12 of the NHS budget is spent directly or indirectly on litigation." Summarising these concerns from a midwife's viewpoint, Jones (1990) maintains,

> 'Increased obstetric intervention is a cause of concern for many midwives, and as the clientele become more aware of their rights and want more participation in their care, midwives are forced to become more litigation conscious. There is also a growing pressure to provide a more cost-effective service" (ibid 1990:136).

*Fourth,* economic rationalism does not encourage the recruitment and retention of highly skilled health care practitioners. In Bingham, management ensures that cash resources are saved because both the pay structure and working conditions of team midwives have been redesigned[16] to:

(i) Eliminate the costly employment of high graded staff at week-ends

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[16] But according to the Trust Management Accountant for this directorate, the merger with Warnick means that Bingham midwives will be reverting to national pay structures and conditions.

(ii) Eliminate special duty payments

(iii) Give midwives a flat rate salary incorporating public holidays, night shifts and back shifts and

(iv) Incorporate 13% sickness absence within their team to cover short-term sickness so that cover may be sorted amongst the individual team members.

Since retiring higher-grade staff were not replaced, it was possible to increase the number of low-grade midwives at no extra cost, a move which maximised cost efficiencies on staff deployment. The full extent of this shift and the responses to it by the lowest paid health care practitioners were not possible to capture, as management were reluctant to allow interviews with team midwives. Harrison and Dixon (2000:99) point out the "inevitable tension between the aspirations of staff and the goal of cost control", claiming that "neither the centre nor the local NHS is well equipped in terms of knowledge, information and expertise, for its responsibilities" with regard to pay settlements.

A criticism about the lack of skills of team midwives came from a team leader.

> "Personally, I would think that in the teams, in time, we will become slightly de-skilled. I would think we would become rather more general rather than specialising. Certainly, you can't specialise in labour ward while working in the teams. If you're in one place all of the time you get good at it. So, therefore you're not really concentrating your skills on any particular area and will never be as skilled in one area." (team leader).

Another participant also questioned the wisdom of setting up Bingham's team midwifery pointing not only to the shallowness of their comprehensive skills but also to the lack of

nursing background of Direct Entry Midwives.[17] Since most team midwives at Bingham are direct entry midwives, she felt that it did not help the already constrained situation.

*Fifth,* economic rationalism breeds a parsimonious budgeting system that keeps budget holders on their toes and focused on cost.

> "Basically we don't have enough money to run an excellent health service. We don't have an excellent health service - at the moment – but we do have one that delivers good value for money, so you're not wasting resources. It delivers effectively. The problem does not have a quick solution to it. If you just dump a huge amount of extra money on the health service, you would not get a great service overnight from that. You have to do it incrementally. And you have to include training and attitudes of staff. So, the whole thing grows. At the moment though it's stopped growing and it has not been growing for a good many years" (Clinical Director).

The Clinical Director's budget comes from the Health Board and distributed to the Trusts according to a case made to the Health Board by each Trust. Budgets are partly historical and partly take into account any new developments. Within the Trust, the budget is divided up between the various directorates on the same basis: partly historical and, in addition, a case is made for any innovations or new drugs. However, within the directorate, allocations are, in general, historically based.

The clinical director explained:

> "The base line budget is permanently screwed down so tight that there are serious difficulties in breaking even, financially speaking. And the more efficient you are, the harder it gets because for a few years time there was an expectation that every year you would find an extra 2%, or whatever, savings within a budget that is already very tight. The difficulty is that there is no margin. You can neither generate money from outside with any ease nor is your break-even financial position a good measure of the quality of your service. It's one measure but it's not the best measure. The best measure is consumer satisfaction. But improved consumer satisfaction will

[17] Direct Entry Midwives do not hold any nursing qualifications before embarking on a three year midwifery course

not allow[18] us to adjust our budget."

What is known about consumer satisfaction is more often than not obtained indirectly through processed research documentation rather than from service users who are serviced directly.

*Sixth,* economic rationalism involves, ironically, the setting up of financial monitoring systems that can, in some measure, be costly. The overall impression is that much effort is exerted and money spent to ensure financial efficacy. The same is not true for ensuring that quality of care is closely monitored to ascertain that social health policies are implemented in practice. The monitoring of finance in maternity care, and in the health service generally, has no equivalent complex bureaucratic structure which monitors quality of care. The fragmented efforts of internal and external researchers who try to measure or assess quality of care do not match up with the self-sustaining hierarchy of finance personnel. Indeed, even those involved in efforts at clinical governance were, at the time of writing, short of cash resources and unable to get the system up and running. Pointing out this problem, Clinical Director replied,

> "Yes that's true - but you can't have it both ways. If you want good financial information, detailed financial information and good financial control, you have to invest in financial control."

In response to the question as whether such extensive financial information is useful,

> "You get to the point where I think a lot of information isn't used. I think we're shading into the area where we're trying to collect too much information. I would rather see the financial controls, at least level pegging, maybe relaxed slightly and the controls on assessing what the service actually delivers beefed up considerably. But more people are needed to deliver on that, to get more feedback, more effective IT systems" (Clinical Director).

On a day-to-day basis, clinicians are expected to think more carefully before consuming

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[18] The participant here means 'enable'

resources. Yet in recent years the number of reforms leading to costly changes in management structures have been criticised for not bringing any direct benefit to service users. Some changes, such as trimming down the number of health practitioners or recruiting low skilled practitioners may solve short term funding problems but they are likely to reduce the quality of provision in the long run, whilst a stressful clinical environment increases the chances of clinical error leading, in extreme cases, to legal action.

### *5.3.2 Continuity of care in Bingham*

One of the objectives of *Changing Childbirth* was that 75% of all women should be attended in labour by someone known to them. Murphy-Black (1993) maintains that the definition of continuity of care depends very much on the point of view, whether it is that of the provider, patient or health care system. Murphy-Black points out that continuity of care and carer in the fullest sense[19] is typically given by the independent midwife rather than by the hospital or community midwives. Taking a more critical approach, Currell (1990) argues that continuity of care is an imprecise and not a necessarily helpful concept and that it is not a cure for all ills as is presumed in maternity literature. The concept "could usefully be replaced by the concept of 'unity of care'" (ibid: 1990:156).

The call for continuity of care has come about as a response to the adverse consequences of the earlier fragmented provision. By 1978, two thirds of midwives were working solely on one aspect of maternity care: for example, in antenatal clinics, antenatal wards, labour wards, postnatal wards, or the Special Care Baby Unit. When Bingham changed to the team midwifery system, the aim was to remove fragmentation and bring about 'unity of care'. The impression given by the clinical services manager was that the

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[19] In a one to one model of midwifery care, the service user would typically see the same midwife about thirteen times during the antenatal episode alone.

system partially grew from the grass roots and was not entirely imposed upon by management. The initial intention was to experiment, explore ideas and listen to suggestions and eventually the system shaped itself up to what it eventually became. She also claimed that some of its success is due to the support given to midwives by the medical team.

In Bingham, about 80% of service users are never seen by a consultant and those who do see a consultant do not necessarily see the same practitioner. During some of the visits, an associate specialist might see them instead. Continuity of care usually refers to the services of a midwife. In Bingham, one or several of the team's comprehensively skilled midwives would care for the service user. According to research evidence by Morgan et al. (1998), midwifery schemes based on shared caseloads seemed to be acceptable to women and are associated with high levels of satisfaction.

A study by Allen et al. (1997) shows that 66% - 86% of women felt strongly about having the same midwife throughout whereas 6% - 10% felt continuity did not matter at all. However, after the birth, the majority of women said that they did not mind seeing other midwives during labour. Some women said they welcomed different opinions and described having a pair of midwives as "reassuring" and "practical to know someone else" (Allen et al. 1997:112). Most women, whose 'named midwife' was present during the intrapartum episode, said that it mattered a lot to them that she was there. The main reason for women wanting their 'named midwife' present during labour was that she offered, "reassurance, increased their confidence, gave security and provided familiarity" (ibid 1997:112). Trust was clearly a keynote for some women and more essential than routine continuity of care. Furthermore, what seems to be more important than type and structure of continuity of carer is its content, namely: 'friendliness of midwives and the reassurance and support they provided' as well as women 'feeling in control and involved in decision making' (ibid 1997:112). Indeed, unless continuity of care is underlined by quality care that focuses on the needs of the service user, it loses its appeal and significance. Wolf (2001), for example, highlights the importance of

emotional support particularly during labour.

*5.3.3 Cumberledge and economic rationalism*

Whilst the ethos and consistency of care provided by midwives would seem to be more important than trying to achieve a narrow definition of personal continuity of care, it has been pointed out that staff holidays, sick leave or departure of key staff can lead to disappointment for the service user particularly when a good interpersonal relationship has been established prior to the midwife's departure. The type of team midwifery at Bingham seems well equipped to overcome such problems.

> "What many groups are doing now is they work the shifts into the four week period, and if somebody does go sick, we phone a colleague and somebody who is off will come in and do it but she'll get an extra day next week, you know. They work very flexibly and it doesn't cost anything"[20] (Clinical Services Manager).

Saving money through the process of negotiation is a key theme to those who were involved in restructuring midwifery care in Bingham between 1994 and 1996. Senior staff claim that their system provides a fair degree of continuity of care at no extra cost to the public purse. The clinical director, who ultimately oversees all financial decisions for the Maternity, Gynaecology and Paediatrics Directorate, gave further insight into the costing aspects of continuity of care.

> "You can use the same ninety staff to deliver the same service at no extra cost but if you organise them into teams, you get continuity which is better from the patient's point of view. You get better staff training because the staff are involved in all the elements of care instead of being stuck in one little niche, like say a postnatal ward, where they tend to become de-skilled say, in terms of labour management. You can't get ideal continuity without putting enormous sums of money in. You can't have an individual personal

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[20] In Bingham, sickness absence is managed very rigorously. The amount of red tape that seems to be involved when a member of staff takes sick leave is likely to discourage staff from taking days off lightly. Apart from the standard self-certificate, staff are expected to attend a return-to-work interview, complete an action plan and, if necessary, they are referred to Occupational Health.

> midwife that sees them from beginning to the end of their pregnancy and nobody else intervenes because that individual could carry only a very small caseload. This would be very expensive."

Thus, cost is measured according to short-term budgeting criteria imposed by the Trust whilst the long-term costs of any consequential health loss are neglected. When DOMINO[21] was in place in Bingham and elsewhere, it proved to be a very healthy and popular system with both staff and service users. This procedure, however, was seen as very expensive because community midwives used to be paid for on-call work on top of their eight-hour working day. Moreover, in practice, a midwife could only be on-call for one patient at a time. With the style of team midwifery practised at Bingham, there is no extra cost incurred for the delivery episode if it occurs after 5.00 p.m. because of the overlapping flat rate shift work system which operates for all midwifery teams. A summary of the logistics of team midwifery, and how it contributes to continuity of care, was given by the Clinical Co-ordinator:

> "There's seven to eight members in each team and hopefully they're seeing the same member of staff from the start of their pregnancy all the way through pregnancy - other than Day Care - when they come in labour and postnatally. And that's got to have a positive effect on the patient because the patient is less anxious when they come into hospital because they're not going to meet somebody they've never met before. I mean occasionally it won't work like that because people will be off sick on the same team. They might have more than one patient in labour at the same time. Therefore, somebody else will have to look after the patient. But, hopefully at some point, when they're in the hospital, they are going to see a midwife that they do know - perhaps met in the parentcraft class. And because they know them and they know them to speak to and they can ask them questions, the anxiety about what's going to happen in the ward is not going to be as serious as it used to be. And that's got to make it a less stressful experience for the patient."

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[21] This is an abbreviation of DOMicilliary IN and Out. It is a plan of care where the community midwife assesses the woman in her own home prior to accompanying her at the appropriate time to the maternity unit for delivery. The mother and baby return home at around six to eight hours after delivery and domiciliary midwife care continues.

Whilst the system described above goes a long way towards maintaining a relatively strong practitioner-service user relationship within a rigorous financial plan, it does not match the extent of care provided with the more expensive DOMINO system. The management team were keen to report how a fair degree of continuity of care in Bingham has become a possibility, even within constrained resources. The downside, however, is that team midwives are likely to work under somewhat stressful conditions owing to their low skills and low staffing levels. Moreover, an inexpensive remuneration scheme, which does not follow the national pay award, is another 'economically rational' setback, especially for team midwives.

### *5.4 Sharing information: some aspects of NPM and maternity care*

Ante, intra and postpartum care is dependent on the flow and substance of information amongst clinicians and amongst clinicians and service users. Electronic record keeping, the frequency of meetings, and the cohesion of midwifery teams are some of the aspects that engender good communication flows. According to one midwife, the implementation of team midwifery itself has brought about improved interaction between doctors and midwives.

> "I think with the team midwifery now, the obstetricians and the midwives are really meeting more. You know, the midwives are going to clinics and meeting the obstetricians there and the obstetricians are all in here every morning so that they're meeting all midwives every day now, whereas before team midwifery we never spoke to obstetricians unless we were actually needing something. I feel they're coming in and out a lot more. We're seeing a lot more of them[22]. Whereas, before, it's been left to the sisters to communicate with medical staff.

The Bellham Acute Hospitals NHS Trust Board recognises the importance of communication and it was an issue under scrutiny at the time of fieldwork. Effective

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[22] One consultant corrected that obstetricians have always been present at the clinics. However, since team midwifery started, all midwives have turns in the labour ward and are, therefore, able to meet obstetricians.

communication is essential for any organisation if it is to perform optimally. In particular, continuity of care would be seriously disrupted without effective communication amongst clinicians and choice would become a non-issue unless service users and clinicians are prepared to discuss options openly and fully.

Although at the time of fieldwork teams had been established for four years, sometimes midwives found it difficult to communicate with other team members because, despite overlapping shifts, midwives have clinics to see to once they take over someone else's shift. As a result, a 'communication book' or a 'diary' was introduced in order to ensure some continuity.

> "We keep a special diary where we include anybody that has any identifiable problems (and) here, the patients carry their own notes. We use the computer when people forget them."

Computerised notes aid cross-clinical continuity, but according to one consultant obstetrician, communication with patients needs to be improved.

> "The things that we do badly ... it's communication with patients. We do that very badly. Both nurses and doctors, but doctors more so than nurses probably" (consultant obstetrician).

In the Allen et al. (1997) study, communication was an area which some women regarded as problematic because, for example, of an absence of guidelines and the reluctance on the part of practitioners to share information and to keep others informed. The Clinical Director at Bingham suggested that clinicians need to be trained in effective communication and for communication to be a substantive element in medical training.

> "At the moment, things that select you to be a doctor, for instance, are some A grade passes at High School. And with that, you may be a brilliant communicator or you may be totally useless at it. But that element of your personality will not much hamper your progress within medicine. It does however greatly hamper your effectiveness in delivering a first class service." (Clinical Director)

Indeed, it is also believed that good communication can effectively reduce the number of

lawsuits. Honestly appraising the issue of litigation, the clinical director felt that the onus is on medical practitioners to explain the situation to the service users or patients as the sequence unfolds. There is a need to keep the service user informed every step of the way so that she may weigh up the pros and cons before she comes to a decision. Another consultant added that owning up to clinical error early on is the best way forward.

In Bingham, an awareness of the benefits of good communication extends beyond the coalface. The use of clinical cascades, which allow information to flow from the Trust Board to clinicians, is an innovation that attempts to ensure that all practitioners, at whatever level, are given the opportunity to hear updates directly from the executive directors. Although it is the Board which ultimately sets the agenda,

> "At least they are prepared to communicate down here about what is happening which I think, maybe did not happen so much in the past. We didn't hear from top management very much" (F Grade midwife).

Contrasting with this impression, was a criticism made by a sister who held a very negative impression about those in authority and described public consultations as:

> "A PR exercise ... it is like investors in people which looks good on paper, balancing work with home work. They are not interested in you or your home at all. They like to think they are. As I say it's a PR exercise. Sorry, I'm cynical."

She was also critical about Binghams's internal managerial approach.

> "Management is so much more intimidatory nowadays, much more intimidatory than it used to be. There's still autocrats about."

Such critical comments, which conflict with the official image conveyed by senior staff, were usually whispered and explanations muffled. Indeed, this dismal picture more accurately corresponds with some of the literature on NPM. Not only do managerial cultures vary from one organisation to the next, but the perceptions of them also seem to vary from one individual to the next within the same organisation.

Another feature of NPM, evident within this site, is organisational turbulence. One team leader maintained that team meetings have been on hold for a while owing to the uncertainty about the future. However, another threw a different light on the matter.

> "As we become more confident in each other and in the concept, we now only meet if we have identified problems. So if we know that there are two or three things coming up that we'll need to discuss as a team, we'll have a meeting" (team leader).

In Bingham, some structural aspects of NPM have led to anxieties and uncertainties about the future. However, owing to its general ethos, there is a keen awareness of the need to improve its communication system which, at the time of fieldwork, seemed to be well under control.

### *5.5 The professions: some aspects of NPM*

The impending merger with Warnick plays a large part in the organisational turbulence referred to above. When asked about the likely effects of the merger, one senior midwife replied:

> "It's bad enough with four consultants who may do things all just slightly different but when another four consultants come in, you're talking about eight consultants there, and it might be eight totally different approaches " (senior midwife).

Continuity and quality of care is partly about providing care by practitioners with similar philosophies or approaches to maternity care. However, the quote, above, indicates that the size of the unit could determine the extent of shared philosophies. Moreover, although midwives, consultants, and other practitioners work in partnership, midwives and medical staff tend to express themselves from their own distinct disciplinary viewpoint[23]. Even amongst midwives, those who work in the community do not share

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[23] One example is the sharply contrasting approach to CAM by midwives and medical staff.

the hospital ethos, which directs core midwives. Nevertheless, despite traditional splits in clinical approaches, one team leader claimed that team midwifery not only devolved power to the midwives by flattening the internal hierarchy, but it also gave them more autonomy and a professional partnership with medical staff.

> " Each team ... works *with* the consultant. We don't work *for* him. So if we have any queries, we go to him. Over the last four years, we have actually changed some of the processes of antenatal care. Now we take to him what we want to do and we discuss with him what we want to do and if (there are) no glaring obstetric reasons why it can't be done, we then relay that to GPs and other health care professionals."

The uniqueness of this ethos at Bingham was further highlighted when a midwife compared the midwife-consultant relationship at Bingham with that of the neighbouring maternity unit.

> "Whereas the ones at Warnick you just don't approach them because they're the doctor, the consultant and that is their status."

I pointed out this matter to a consultant obstetrician who observed,

> "Teams have changed the midwifery hierarchy a lot but have not altered the relationships between midwives and consultant staff to any degree. Most of the observed difference reflects personalities. But, it is true patients are seen much more by midwives as 'their' patients and so I feel the midwife is more ready to contribute in discussions with medical staff. I think the teams also know the patients better, which also has a positive effect."

One midwife narrated an incident she had with one consultant who originally refused to allow her to artificially rupture membranes. She recounted how the consultant asked her to put forward her case in writing. He eventually consented.

> "Consultants now are much more open, more modern and they've kept up with the times and they're all listening to us" (team leader).

The midwife-consultant relationship is relatively smooth at Bingham and the overall indication is that this relationship has matured.

> "The idea that midwives are handmaidens no longer exists in this unit[24]. If we identify deviation from the norm, we would inform the medical staff. And that's what our rules say we have to do anyway. And that's working in partnership. It's a change in perspective in the 8 years I've been here. Very big change in perspective."

However, the partnership between midwives and obstetricians is not necessarily shared by midwives and GPs, "a lot of them, won't be open to change." One team leader described the situation:

> "And I think because we are a team, it's not a community midwife just being told what to do by her GP. I think we can answer back and you know stick up for the women and stick up for ourselves as well. It's not just midwives who are trying to change things. I would like to think that a lot of GPs will eventually."

### *5.6 Summary and conclusions*

The managerialist features operating in Bingham are, (i) a regime of tight cash limits and cash planning resulting in; (ii) staff cuts or the replacement of high skilled with low skilled staff; (iii) a stress on economy and efficiency as shown by the imposition of new working conditions for team midwives and; (iv) evidence of greater cost consciousness.

In Bingham, efficiency improvements have not resulted in drastic quality or service reduction. Its team midwifery system provides a reasonable level of continuity of care within a limited budget whilst offering service user choice, which nevertheless appears to be circumscribed by professional and organisational dictates. Launching Bingham's team midwifery meant creating a new pay structure for midwives and the replacement of highly skilled with a larger number of low skilled midwives. Whilst team midwives appear to have rigorous, albeit flexiblised working conditions, the overall impression given by team leaders and managers is that team midwifery provides optimum maternity care overall, describing it as "effectively, a better deal for the same amount of money."

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[24] In contrast, one Bingham consultant claims that this has never been the position in Bingham.

Team midwifery at Bingham manages to iron out some of the usual problems associated with service user demands and human resources costs. Their model has redefined maternity provision, making it, according to interviewed clinicians, beneficial to the service user. Bingham's managers also claim to have made better use of available human and cash resources than the traditional model. The only shadow that seems to loom over this system is the question of how satisfied midwives are with pay and working conditions and how expert they are in each of the areas of midwifery care they provide.

In an attempt to resolve tensions between cost limitations and practice, budget holders and senior staff are expected to, (i) eliminate waste; (ii) cut down on staff and; (iii) minimise skill levels to reduce labour force expenditure. In recent years, the increasing awareness by the service user of her right to choose has conflicted with these cost constraints. Although team midwives' cost awareness has been sharpened and the cost cutting initiatives narrated by participants do not seem to have interfered with service users' choices, cost limitations do shape what is available to the service user within the hospital as a whole. Moreover, service user choice is not only influenced by midwives and the midwifery system in place but is also shaped by obstetric orthodoxy.

Unlike *choice*, the achievement of *continuity* of care is closely related to infrastructural aspects: for example, how time and human resources are deployed within midwifery and obstetric units. The merging and co-ordination of skills and the communication system play a significant part in optimising continuity of care for the user. Within an economically rational framework, cost considerations have imposed limits on the proper funding of an optimal team midwifery system which requires high practitioner to user ratios and stress-free working conditions.

The importance of good quality communication systems is recognised in Bingham both in terms of IT systems for record keeping, as well as service-user to practitioner and practitioner-to-practitioner relations. In Bingham, the setting up of team midwives has

not only improved midwife-to-midwife interaction but seems to have improved midwife-consultant relations as well. Indeed, what cushions Bingham against the adverse effects of economic rationalism are the apparently good interpersonal skills with service users and the way in which consultant obstetricians and the medical team support midwives. At least this is the picture conveyed by Binghams' health care practitioners rather than necessarily service users themselves.

# Chapter six

## Site two: Crighton Maternity Unit

### *6.1 Introduction*

The first part of this chapter describes the clinical setting at Crighton. It looks at the present role of the midwife, the community midwife, and organisational plans for the future. The second section describes the financial infrastructure analysing participants' views on their experience of the current budgeting process. The section that follows examines how economic rationalism impacts on community midwifery, user choice and continuity of care and concludes that forces, such as obstetric orthodoxy, can be as powerful as the grip of NPM in obstructing selected social health policies. The final section examines the part played by NPM on type and level of clinical stress, the quality of communication amongst health care practitioners including inter professional clashes and conflicts.

### *6.2 Crighton: The setting*

Crighton, a very large maternity teaching hospital adjacent to the city's main general hospital, serves a cosmopolitan population with a mixed socio-economic spread. The catchment area is largely urban/suburban. The unit trains both medical and midwifery staff. The main obstetric ward for the majority of service users is high-tech but the hospital also houses one poolroom and has a small low tech Normal Delivery Unit (NDU) with three beds in three separate rooms, as well as a four-bedded High Dependency Unit (HDU). Of the eighteen obstetricians, eight are male and eleven are female.

Crighton's employs approximately 323 midwives. The operational manager who oversees the whole unit is an H grade midwife whilst the two community team leaders are G grade. Another senior midwife[1] (G Grade), who has a managerial role within the hospital, described herself as a 'clinical expert' who oversees and manages the clinical and personnel aspects of the department such as sickness and absence issues, professional development and leave. The five clinical managers, who are at least F grade, function as midwives as well as overseers of the budget in their section. Grade G (senior) midwives may act as team leaders or clinical managers, whereas Grade F midwives have fixed posts in either the ante, intra or postnatal areas of the hospital and are permitted to co-ordinate on given days. Grade E midwives are not sufficiently skilled to act as co-ordinators. They have rotating posts providing interim care in ante, intra and postnatal areas of the unit.

At the time of fieldwork, there were two community midwife teams each led by a G Grade midwife. At present, this Unit is attempting to increase (sometimes in face of opposition from midwives) the number of community midwives[2] as well as to

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[1] During fieldwork new clinical managers were being appointed and new posts for non-budget holding senior midwives were also being established.

[2] The plan to increase the number of community midwives involves sending the majority of existing midwives out into the community to care for women in their homes and in local community-based clinics.

increase the number and skills of existing and incoming midwives. Figure 6.1 shows the composition of clinical staff from which the participant sample was drawn.

**Table 6.1 Composition of clinical staff at Crighton**[3]

| |
|---|
| 18 Obstetric/gynaecological consultant [on call cover] 6 of these are neonatal |
| 22/5 Middle Grade Staff [registrars and senior registrars] |
| 22 Senior house officers |
| 323 Midwives (headcount: includes hospital and community midwives and 7 senior midwives) |
| Various student midwives and medical students |

*Source: These figures are not precise and are partly disclosed by senior members of staff and partly drawn from ISD workforce statistics.*

In 2000, when fieldwork was conducted, Crighton was in the throes of various changes; in particular, new management structures meant new roles for some and the prospect of moving to a new site brought about many uncertainties. Participants' anxieties are also linked to the Trust's plan to reduce the number of postnatal beds in the new site and the need to schedule time and find the resources to train more community midwives.

Crighton currently delivers between 6000 and 7000 infants a year. Out of these, about 50 are home births. When the maternity wing at the new hospital opens, it is planned to get the majority of midwives out into the community working in teams and working towards developing caseloads. The small number of core midwives who will be hospital-based will act as support and back-up for community midwives who will bring the women into the labour area for their deliveries or attend to women who develop problems during their pregnancy.

[3] For a full description of the number and status of the 31 Crighton participants, see supplement at end of chapter four.

### *6.2.1 The Normal Delivery Unit*

On average, NDU is expected to deliver three women every 24 hours. But the unit has, on rare occasions, seen five deliveries in 24 hours or as little as one in 24 hours. NDU's ratio of staff to users is 3:2 or 1.5 midwives per woman. This is the figure recommended by the Royal College of Midwives. Staffing levels are perceived as ideal by NDU midwives except on rare occasions when three women are delivering simultaneously.

The women who deliver in the NDU must meet certain conditions relating to their health, in particular the expectation of a normal pregnancy and labour. This is an unusual understanding of the concept of 'normality' because, ironically, only a very small minority may be booked into the three-bedded NDU. Booking in for the NDU depends on whether or not the service user has heard about it from her GP or community midwife. Whilst it is possible for service users to be moved from NDU to the obstetric unit if and when unforeseen complications arise, service users from the obstetric ward are denied access even when they fulfill the 'normality' criteria as pre-booking is a requisite. On occasion, NDU staff are 'borrowed' for the obstetric unit when extra staff are needed. Sometimes, this has lead to the temporary closure of the Normal Delivery Unit

The differences in approach, ethos, staffing ratios and environment in the two wards are dramatic. NDU midwives differ significantly in their philosophical approach to childbirth. In the peaceful and relaxed atmosphere of the NDU, service users can expect a reasonable amount of continuity of carer - at least within the intrapartum period. In the obstetric ward however, all considerations - such as choice and continuity take second place to clinical pressures and the obstetrician's clinical understanding of safety. Not only is the understanding of safety tinged by the perspective and experience of the practising midwife or obstetrician but it is also a concept that needs to be re-defined each time to take into account the clinical environment such as the availability of staff and other resources.

### *6.3 Some aspects of the role of the midwife*

The role of the midwife in Crighton is both qualitatively and quantitatively significant. Referring to the lead practitioner during the intrapartum period, one consultant informed that about 60% or 70% are midwife cases. In general one is led to assume that, "the midwife's focus is on the normal." When midwives, "detect the abnormal, (they) pass it on to the medical staff." According to one NDU midwife, Crighton harbours at least two different types of midwives: those who originate from the smaller low-tech units and those who have trained and have always worked in a large high-tech unit. The latter, often call themselves obstetric nurses although one senior midwife argued that midwives in the obstetric ward have an *extended* role rather than a purely *medicalised* one.

Findings suggest that a new identity for nurses and midwives seems to be emerging. The two contrasting views below, however, suggest that their role and self-perception is in transition.

On the one hand,

> "Members of staff do not have problems standing up voicing their opinion even if they are short of time, but midwives are a lot more protective of themselves and a lot more tentative in expressing an opinion."

On the other,

> "I think no longer are nurses coming into the profession with the same cultural expectations or backgrounds that our staff trained in. And they are very questioning. They're not complacent. They're challenging, they're enquiring and again this is making our medical colleagues realise that no longer do they have the domain, the right to dictate. Certainly in this unit there's been a big shift in terms of how we work together."

#### *6.3.1 The role of the community midwife*

Community midwifery flourished around the fifties but by the mid-sixties around 95% of care became hospital based. During the last ten years there has been a gradual U-turn so that at present there is a two way movement: one is the closure of

small units with a view to centralising maternity care and the other is an increase in the number of satellite clinics in the community.

> "Care in the community works because women who couldn't or wouldn't come into the main hospital area could receive a good standard of care from consultants, midwives and GPs in the community setting."

The concept of community midwifery, whether it organises itself into team or caseload midwifery - is expected to allow more room for choice and for continuity to flourish. When community midwifery was taken to certain disadvantaged neighbourhoods within the Crighton catchment area, midwives followed women in the community to try and establish a trusting relationship with women who, in the past, have tried to avoid antenatal care.

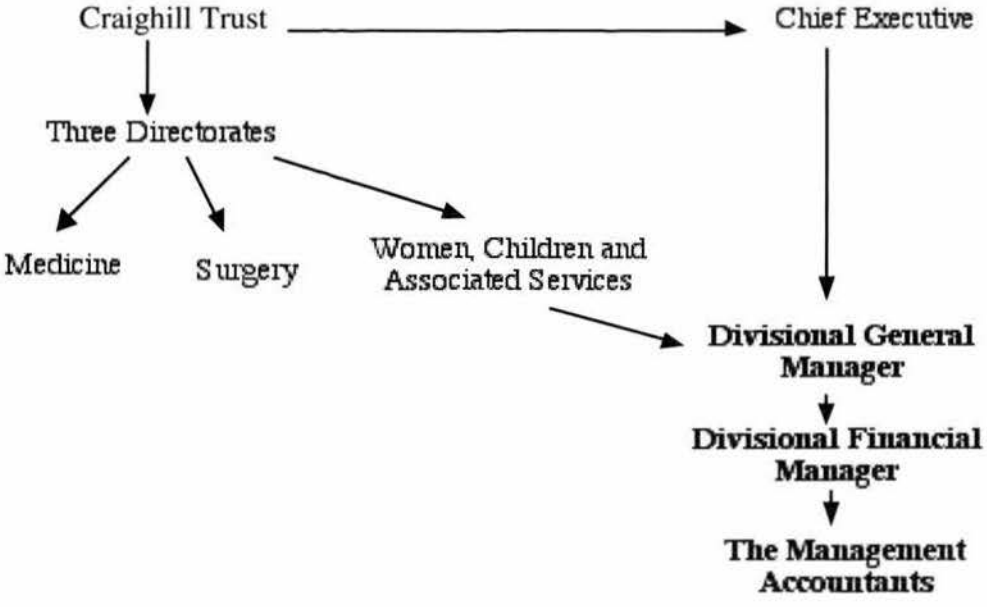
Community midwifery at Crighton is organised in teams. There are two teams each headed by a team leader. The approximate size of team is eight full time equivalents. There is a *named midwife* system in place for low risk women and a named lead practitioner for high-risk women who receive early obstetric care from medical staff. Although community midwifery is meant to promote continuity of care, the community midwife is not involved during the intrapartum period.

In Crighton, community midwives are F or G grade. They are more autonomous and more isolated than the hospital midwife who is given heavy workloads and twelve hour shifts including on call shifts. Apart from the skills of midwifery *per se,* community midwifery requires a complexity of additional social skills beyond the experience of the newly qualified midwife. Direct entry midwives whose course lasts three years would need a further two years experience before they can become a community midwife. Thereafter, they are trained under mentorship. According to senior staff, effective community midwifery in the Crighton area would require a substantial up-levelling of the skills, particularly in intrapartum skills. Whereas the old midwifery system meant that midwives were designated to antenatal or postnatal or intrapartum wards, the impending conversion to community midwifery means that midwives have to be skilled in ante and post partum care and potentially intrapartum care as well.

### *6.4. The Financial infrastructure*

Insight into the way the financial machinery is driven and the underlying costing policies of maternity services were obtained from an informal interview with the Divisional General Manager (DGM) responsible for Women, Children and Associated Services. The philosophical basis underlying the reviewed system includes managerial clinical networks as well as the idea of getting away from operating from site basis as outlined in Sir David Carter's 1998 Review Report: *Acute Services*. This effectively means *reduced* competition between trusts thus allowing management structures to collaborate. Under the paragraph headed *Replacement of the Internal Market*, the Review Report suggests that there is a "need for co-operation, the breakdown of organisational barriers, and improved communications (as well as) improving clinical links across the interfaces between primary, secondary and tertiary care" (SODoH 1998).

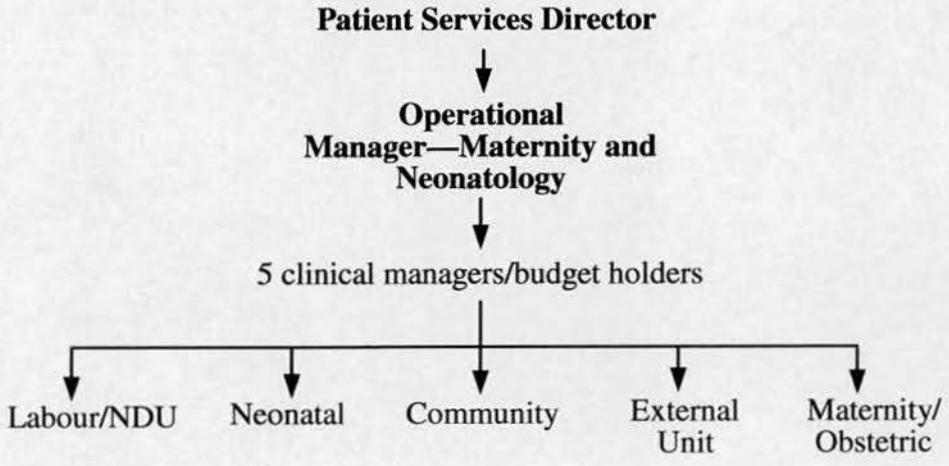
**Figure 6.1 The external monitoring of maternity care funds**




I gathered from the DFM and the management accountants that their task is largely cyclical consisting of monitoring overall, in case of the DFM, income and expenditure within the directorate, whilst the management accountants monitor

selected areas within the larger remit. Monthly statements[4] are sent out to individual clinical budget holders for review, comment and verification. It is up to the DFM and management accountants to query any unusual over or under spending in a particular area. Within Crighton, Maternity and Neonatology is split into five areas - each with their own budget-holding clinical manager. Figure 6.2 shows the direction of funds.

**Figure 6.2 Budget management by clinical personnel in Crighton**




Apart from budget holding, the five clinical managers also have midwifery and staff management duties. Interviews focused on the clinicians' experience of the budgetary procedure and the way in which this process impinges on social health policy, specifically the implementation of service user choice and continuity of care.

*6.4.1 Budgets*

Central control over the NHS budget changed in 1976 to a cash limited basis. This meant that once the cash allocation was set for a given service in a given year (and also in principle the year to come), that figure could not be exceeded. For the last 20 years or so, the bulk of the budget has, each year, effectively been determined at the start of it and not, as happened before the introduction of cash limits, regularly

[4] See Appendix 7 for sampler budget statements

adjusted in the light of actual changes in pay and prices. Until recently cash limits were not applied to drug expenditure and supplementary finance has been made available in the light of the pay settlements agreed. Despite the overall Treasury-set limit, each main element of cost has needed a policy of its own.

The four main cost categories of the NHS are: i. pharmaceutical products; ii. supplies for non-clinical goods and services and support services; iii. capital projects; and iv. clinical services as a whole (Harrison & Dixon 2000). The authors suggest that the NHS does not have the information and experience it requires to ensure that costs are effectively controlled. The efficient purchase of supplies has remained difficult to achieve. In 1991, the Committee of Public Accounts found that, "...most regions were unable to provide the National Audit Office with a list of the top 50 items by value purchased in the last two financial years or the top 30 suppliers to each region" (pv1, part 5). This means that across the nation, a wide variation in the prices were paid for some goods and "there is a need for a supplies strategy and for establishing a system of accountability since these are not being discharged systematically" (Harrison & Dixon 2000).

According to the Divisional Financial Manager, planning the cost of maternity is easier than planning the cost of other services. Since maternity care is an elective type of service, as opposed to a service such as Accident and Emergency, cost and planning are relatively trouble-free. Nevertheless, aggregating costs in health care can lead to serious inaccuracies because activity and cost are not so finely tuned, and may bear no relationship to one another. For example, the lack of certain clinical qualities such as credence and competence cannot be costed. Nor is it easy to assess and reward the performance of any individual or group because no one doctor or nurse is responsible for all of a patient's treatment and associated recovery (Jacobs 1994). Apart from factors such as clinical incompetence, or lack of experience that may result in long term unforeseen costs, there can be huge discrepancies in costs incurred by one user and another even when they are getting the same treatment because, for example, the length of treatment is dissimilar.

Whether one considers the whole of health care spending or discrete specialisms

such as maternity provision, care is always circumscribed by cost accounting - a process that is based on complex and sometimes not wholly accurate clinical assumptions. Sometimes important decisions about health care spending are far removed from clinical needs and realities.

In Crighton budget holders reported that they are restricted in the ways which money can be saved or spent. 'Historical' budgets fail to address the gap between current needs and current resources. The 'rational' prioritising of resources is transmitted wholesale down the financial hierarchy irrespective of what needs to take place within the hospital ward. This 'up-down' practice does not allow new ideas in resource management to see the light of day. In addition, the pressure to reduce or contain spending means hospitals are not able to operate in a way that emphasises quality and service user control[5].

> "I think we should have budgets which are realistic and these are not. These are historical budgets and have no semblance to what is actually required. If you looked at what was required to provide the service and then added the money to it - that would be a more effective way of doing it. But what we have is, 'that's the amount of money you've got - then you provide a service with that.'" (Operational Manager)

The operational manager described budgets as historical, ineffective and out of touch with present day maternity needs and voiced her disapproval of present budgetary arrangements, complaining that restrictive procedures leave no room for creativity, innovation and entrepreneurship.

> "I would like to have some means within the budget to be able to identify a pot of money or to ring-fence so I could use that to update equipment and to have a rolling programme. That's good financial management to be able to do that. But there isn't the facility."

She felt that it is not cost effective to have a divisional team deciding on a very small amount of money. The operational manager and the five budget holders expressed a range of constraints.

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[5] 'Service user control' in the context of *Changing Childbirth* means that women are allowed control over their birthing experience.

(i) lack of manoeverability

> "Our priority for the whole Trust in the next 12 months is to work with the new budgets to try and minimise the overspend and within that, you have a very small margin of manoeuvrability. I mean I might want to replace equipment say, within the maternity unit. Now I wouldn't be able to do that out of my existing budget. I would have to do that from our capital funds, which are central funds, or hospital endowments which we are fortunate to have. Our hospital has big endowment funds. But I wouldn't be able to purchase any significant (up to £5000) equipment from my budget."

(ii) excessive red tape

> "There is too much control over spending. Although I have a budget of £M16, I am not allowed to draw cheques for over £2000 and any cheques at all which are over £200 involve a lot of red tape. It takes a lot of empowerment away and it's across the board."

(iii) costly spending controls

> "It's also very hierarchical and very time consuming and hides many costs involved in the administration of finance. If you actually looked at the hidden costs of doing that, I'm not sure that it's a cost effective a way of controlling spending."

The process of rationalising and prioritising does not seem to be based on an honest and comprehensive appraisal of the optimum use of cash and other resources. Often long term health gains are sacrificed for the sake of short-term savings. A representative from the local Birth Resource Centre tackled this point during a public consultation exercise in Spring 2000.

> "In particular, we believe that the financial analysis is full of weaknesses in the assumptions it makes, and that what is really called for to make sound judgments about cost effectiveness is a much more holistic cost-benefit analysis that looks at the host of implications of any given path to services, with all its attendant knock-on effects" (McNeill 2000).

Within an economically rational framework, budgets follow the "self-referential logic of money" (Pusey 1991). Whilst financial management follows a track that is separate from issues concerning social health policy, the budgetary process itself has an unintended broader social significance. It robs time and energy away from

substantive health matters and consequently impinges adversely on the social aspects of health care.

*6.4.2 The experience of budget holding by five clinical managers*

Budget holders have different levels of responsibility and experience and are clearly in charge of distinct areas with distinct needs. However, they all share a sense of restriction, a lack of freedom in the way they are expected to manage.

> "We do not have any say when money is creamed off our budget and each year we are expected to make more and more savings" (clinical manager).

The five clinical managers do not share the same level of responsibility. Their roles and functions are linked to their previous experience. Undoubtedly, however, the sense of restriction is clearly more pronounced than that of the operational manager. One key function, which they all share, is to make the needs of their individual units known at meetings.

The knowledge and clinical insights of these budget holders are barely utilized for the purpose of shaping the divisional budgetary rationale. Statements[6] are issued to each clinical manager every month and any over or under spending is queried by the management accountant or DFM. One clinical manager said she would like to get more intelligible monthly statements which "tell me what I really want to know"

One of the questions put to clinical managers was meant to test out their spending priorities. Tables 6.2 and 6.3 show the results of two hypothetical questions put to them.

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[6]See Appendix 7 for exemplars

**Table 6.2 Question 3[7] Response to increased funds**

If spending on your programme were to be increased by £200,000 p.a., what would you spend it on?

| | 1st choice | 2nd choice | 3rd choice |
|---|---|---|---|
| **Staff** | 3 | - | - |
| **Education and training** | - | 2 | - |
| **Environment (fabrics, painting and decoration)** | 1 | - | 1 |
| **Equipment** | - | 2 | - |

*N=4*[8]

In response to Question 3 one clinical manager in the neonatal unit, whose budget of just under £4 million covers the child welfare clinic and the paediatric laboratory, responded that she would like to see the staffing budget increased in the first instance. However, she also felt that there is a need to invest in the environment as

> "research shows that reducing stress and creating a different type of environment in the nursery would improve our retention and improve our staff attendance."

Three clinical managers said that an increase in staffing would be their first choice followed perhaps by the enhancement of the hospital environment with furnishings, painting and decorating. Education and training or replacing or buying new equipment, came a close second.

[7] See question 3 to All Budget Holders in Appendix 2

[8] Of the five clinical managers (and one operational manager) interviewed – one refused to be taped so that her recorded responses are sketchy; another was newly appointed to the post and did not feel experienced enough to respond to the two questions put to her.

**Table 6.3 Question 5[9] Response to decreased funds**

If spending on your programme were to be reduced by £200,000 p.a., what should go?

| | 1st choice | 2nd choice |
|---|---|---|
| Staff | 3 | 1 |
| Supplies | 1 | 3 |

In response to Question 5 one clinical manager responded that in this situation she would have to consider cutting down on supernumerary posts which are largely associated with education and training. She would also look closely into the use of disposables such as the very expensive gas cylinders needed for transcutaneous monitoring and which are used extensively in her unit.

Another participant decided, after much hesitation and reluctance, that if she would have to let go of staff, qualifying that it would not be core but peripheral staff who have an advisory rather than a clinical role. The participants felt that, in such a case, a review of supplies would have to be made. Evidence collected not only reflects the poor manoeuvrability of their budget holding but also how social health policy issues, such as service user choice and continuity of care have very little direct bearing on their spending patterns. As one participant explained:

> "Women get a service which is dictated by what is available - what's there for them. We provide choice for women and continuity of care and carer within the confines of the service" (clinical manager).

Some budget holders have better opportunities than others to generate income. In the neonatal unit, income is generated through the organization of an annual conference as well as through students' fees. However, the pressure is experienced by all budget holders.

[9] See question 5 to All Budget Holders in Appendix 2

> "We have to meet our cost saving targets but the current agenda in our Trust is very much cost containment. We're very driven, very, very driven by our financial targets that we have to meet. The key objective is to be cost effective, cost efficient with resources and when you can equally do that and save monies, you know you're doing well" (clinical manager).

Although budget-holders have delegated areas of responsibility, they have no licence for risk-taking.

> "The system does not promote creative thinking and imagination. Creativity is crushed. The present system of approval is quite inhibiting - constrained by layers of bureaucracy more inhibiting than safeguarding expenditure" (clinical manager).

Whilst it is accepted that a system of checks and balances to avoid abuse is needed, one clinical manager suggested that:

> "We should give budget holders a bit more scope how to utilise the money so long as they can defend their plan" (clinical manager).

The feeling of disempowerment seems to be about the incapacity to direct funds as much as it is about fund limitations. Despite high levels of clinical skill and budget-holding experience of some participants, they tended to feel crippled by financial decisions formed at Trust level. Not only are clinical managers 'tiny cogs', but health service structures seem to be in a perpetual state of transition causing much turbulence and future uncertainties.

What clinical managers said confirmed the information I was given during an informal interview with the Divisional Financial Manager. The budgetary allocations of each unit are largely prescribed and closely and frequently monitored by personnel outside the clinical manager's unit. Apart from the experience of disempowerment for clinical managers, this situation is a clear indication that social health care policy goals cannot be fully implemented within the dictates of the present budgetary process. Aspiring to improve service user choice and continuity of care remains an issue straddled between the hopes and actions of highly motivated staff and the inaction of highly disempowered clinical managers.

Participants felt that the insistence on the retrieval of unspent monies is awkward,

hindering and punitive. It means that budget holders may hold back funds unnecessarily to start off with, but end up giving back what they have not spent at the end of their fiscal year. Moreover, budget holders are presented with further constraining problems such as the requirement to make a 3 % efficiency saving. This continual constraint caused by ever-increasing service user expectations against diminishing funds cascades down to all clinicians – even those who do not hold budgets. All health practitioners are expected to balance increased activity against diminishing resources. As Pusey (1991) points out 'doing more with less' is a key feature of economic rationalism – a concept whose essential drivers are *efficiency* and the assurance of *value for money*.

## *6.5 Community midwifery, service user choice and continuity of care – the impact of economic rationalism*

This section will briefly examine some of the recent changes in maternity care practice experienced within this site and the plan to launch an extended community midwifery system. It also looks at the levels of service user choice and degree of continuity of care provided and the extent to which the implementation of these policies are hindered by economically rational choices.

### *6.5.1 The experience of change*

In recent years Crighton's maternity care practitioners have experienced a number of changes. Today, the average service user is more aware of her choices than she was a decade ago.

> "Women were grateful for what you did for them but now there has been a shift. I think women are much more consumer orientated - whether you've got long queues, waiting to be seen. I think people are treated much more as individuals. They have more choice, more say. So the way that we provide maternity care has changed, making new demands on the kind of care that they expect from us" (G Grade midwife).

The irony is, however, that the diffusion of a culture of customer charters and the call for services to be client led came alongside poor resourcing of staff. The paradox that this situation poses was expressed succinctly by one of the senior midwives.

> "The way we provide maternity care has changed. We have a lot of women-centred choice out there that makes demands on the type of care they expect from us. Equally a lot of policies and procedures have been looked at in the light of changing attitudes towards maternity care. Therefore standards are higher without further resources[10] to assist us. We just feel it is a catch 22 situation" (senior midwife).

Attitudes towards health care practitioners have also changed alongside the expectation of increased service user choice.

> "We in fact have planned this shift giving them that choice - actually getting them to be more aware of their bodies, how they function, what they should expect. But we also paid the price for that by the higher standards being expected from us. I think that the medical profession are being challenged an awful lot more now" (G Grade midwife).

Added to the expectation of high standards is an increasing demand on other resources such as rising requests for caesarean sections. There is often an acknowledged need to go ahead if there are sound clinical reasons. However, the 'right to choose' could also present difficulties for the practitioner who may not think that such an operation is strictly necessary.

> "Oh certainly, I think expectations have changed. Radically, radically. And I think that is very hard for the staff. They are not used to having their care questioned. They're not used to having somebody coming in their way" (clinical manager).

Nevertheless, the overall verdict by a few midwives is that these vital changes have improved standards.

> "The quality of care, I feel, has changed. The ethos has changed" (G Grade midwife).

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[10] The participant is referring to staff resources.

*6.5.2 Community midwifery*

When fieldwork was conducted in 2000, Crighton was eighteen months away from a move to a new site with fewer maternity beds. Plans included a changeover to a total community midwifery system. In general, both midwives and consultants felt that whilst the reduction of the number of beds would bring about savings, community midwifery was going to need increased funding if it were to function effectively. It was understood that the planned changeover would bring about both cost and time constraints on the service because,

> "... putting more midwives out into the community (means) they tend to be taken away from the labour ward environment which is not a good thing. In order for it to work, you probably need more people to work in the community. People think you can cut costs. Well this community thing is supposed to cut cost - but I rather suspect it won't if you're equipping lots of different centres"[11] (consultant obstetrician).

Moreover, community midwifery is likely to prove more expensive, at least in the short and medium term, because it "involves investment in terms of training." One consultant obstetrician explained how Crighton's hospital midwives were poorly equipped for working in the community. Referring to an encounter with a group of Crighton's midwives at a health centre, she explained that they are

> "only familiar with basic palpation, blood pressure, just routine care such as pressure profiles, CTGs and glucose tolerance tests"

whereas the community midwife requires more extensive skills.

Arguably, the elimination of hospital running costs such as reduced ante and postnatal beds and hospital maintenance costs ought to result in substantial savings. One midwife explained why such a reduction in costs might take place.

> "Our aim is for the majority of women to be gone within 24 hours. If you get a midwife coming in with somebody and delivering her and taking her home then you do have a reduction in hours as well" (senior

[11] The participant is referring to community centres with clinical facilities for ante and postnatal care.

midwife).

However, community midwifery would require specialist midwifery skills and, therefore, an increase in staff salaries, a fleet of cars, increased administration, and other miscellaneous costs. Unless staff numbers are kept to an undesirable minimum, salaries, which constitute about 70% to 80% of the budget, are still likely to outweigh any other savings made. One consultant argued that one-to-one care in the community is more expensive than the kind of care provided in the hospital where one could

> "maybe see ten women in one hour. It could take you one hour just to drive to their house."

Alongside mixed views about the cost of running a community midwifery system, other fears were also expressed.

> "I'm just worried that we will not have the proper support out there - the financial support and everything else to support community midwives."

Most participants envision the move to the new unit with a mixture of positive anticipation and dread. One senior midwife put it bluntly and succinctly.

> "At the end of the day they have a financial budget and we're being fitted into that. They're not providing a service we think we should provide. We have to provide a service which fits into the budget" (clinical manager).

*6.5.3 Service user choice*

A senior midwife summed up the salient issues involved in the provision of maternity care.

> "Continuity and choice are the raison d'être of clinicians as well as clients. We are facilitative. We reflect the needs of women as identified by the midwife" (senior midwife).

During pregnancy and childbirth, women wish to receive accurate and unbiased information to help them make informed choices (Green et al. 1998; Walker et al. 1995; Kirkham 1993). According to Levy (1999), facilitating informed choice is a highly complex activity involving three processes: *orientating* whereby the midwife

tries to understand the woman's situation and wishes; *raising awareness* whereby the midwife sets the agenda and offers choices; and *protective gatekeeping* whereby the midwife suppresses or releases information to protect the woman and herself. These processes are shaped by four key factors: (i) the personal opinion and attitudes of the midwife (Brian 1990 and Marsh 1996); (ii) the availability of knowledge providing the basis for information (Dyson et al. 1996); (iii) the power structure within which midwives work (Davies 1992 and Ralston 1994); and (iv) the available resources (Dimond 1993).

In Crighton, interviewed clinicians agreed that the system does not fully accommodate the new emphasise on users' choice whereby service users are expected to be kept informed and involved in decision-making throughout. The service user is not always able to exercise her right to choose. In Crighton, the average user is more likely to accept clinical decisions rather than the other way around.

> "I think the people who tend to know what they want and make a choice tend to be well educated and know more about what's happening to them. People who don't know much what's happening to their body just tend to let you take over and let you do what you want. They don't think they've got any choices." (E Grade Midwife)

Sometimes the opportunity to exercise choice is perceived as a dilemma by the service user who lacks background knowledge and the confidence that comes with it. It was admitted, however, that the vociferous user is appearing more frequently in delivery wards and, for such users, the exercise of choice is increasingly becoming more than just a remote ideal.

> "They are more outspoken about what they want or don't want. In the past it would need to be medical and professional staff who would decide for them and I suppose patients were frightened when they were in hospital. They tended to do what they were told. They don't now" (G Grade midwife).

This new awareness brings new responsibilities for the practitioner.

> "I'd say nowadays very few people would jab an injection in without asking the mother's permission. I would hope that doesn't happen

anymore. Nobody is going to have something done to them unless they agree to it. But at the same time they might be persuaded to agree to something" (F Grade NDU midwife).

The recognition of user choice as official policy has led to direct service users' demands. However, the clinical context within which user choice is offered or requested is an important factor because it defines the breadth and depth of this concept. Not all maternity units have a 24-hour access to epidurals and as units become more high tech, requests for high tech treatment are also on the increase.

> "There's a lot more people who are choosing to have an epidural before we have even started their labour. And that's a big change from even ten years ago. And we've got into that culture. When I first started my training we had one anaesthetist and I worked in (here the participant identifies the name of a smaller maternity unit). We didn't have an anaesthetist around for every single request for epidural. You got through by support and the use of opiates. That's why a place like (here the participant identifies the name of same unit) had a much higher normal delivery rate. But now you got people come here - because they couldn't be guaranteed an epidural in somewhere like (this small unit) - they came here because we have a 24 hour service." (F Grade midwife)

The principle of the right to choose appeared to be acceptable to clinicians, even if, as one senior midwife explained, standards are expected to be higher without further resourcing to accommodate the change in culture.

> "The procedures are there for them to question things more so than it used to be. People are probably more aware about the fact that they can complain or they can comment on the sort of service they had and I think that's probably why people do comment more than they used to in the past." (G Grade midwife)

Participants described a number of situations that limit user choice.

(i) One NDU midwife claimed that not enough women are aware of their right to choose a home birth. "In most cases nobody tells them that they have the option." Home births are few and far between and require two attendant highly skilled midwives. This choice of delivery usually draws midwives away from other services and, therefore, demands more resources than hospital births. One midwife explained

how the unit does not, as a rule, organise itself around home births.

> "I think it's quite expensive because you have to have people on call and that can be quite expensive. And you also have to have two of them. So there's two women going out. As the birth approaches, a second midwife will join the midwife that's already there. That's two midwives for each woman in labour getting paid overtime. If it's at night or if it happens during the day, they would do what they would normally be doing - maybe miss a clinic or have somebody else doing the clinics or postnatal visits - so you have to shift things around." (F Grade midwife)

(ii) Another service user option that is likely to be curbed owing to cost is the DOMINO method of delivery. A woman may have this option forfeited if, when the day arrives, the midwife is needed elsewhere.

> "We do say we give choice. But having said that, we cannot give full choice. For example, we can only take so many home births at a time. And if there's home births and Domino, the home birth has to take preference."

(iii) In the main obstetric ward, the user who opts for a water birth is expected to have an accompanying midwife throughout. Since the pool in this unit is quite a distance away from the labour rooms, its use is restricted. A midwife explains:

> " There's a pool in the labour ward, it's separate - it's on the same floor but at the other end. For somebody to go into that pool, you need to have a midwife there all the time - which means that midwife can't look after anywhere else, she's too far away from the other rooms. That midwife couldn't look after two people at the same time. The pool is too far away from the rest of the labour ward" ( F Grade Midwife).

Therefore, a water birth is only possible if the main ward is not busy. Otherwise, this option has to be turned down.

(iv) Low staffing levels can have a negative impact on service user choice.

> "We don't have enough midwives and enough time to give real choice" (G Grade midwife).

Service users are more likely to be given the opportunity to exercise choice in the relatively relaxed atmosphere of the NDU than in the busy obstetric ward. A cost comparison between the two wards, which measures both short term and long term

benefits has not, to the writer's knowledge ever been carried out. In the main ward service user choice could just as easily be steered towards costly medical intervention or it could lead to savings if the service user opts for and receives minimal intervention. The increased demand for client-led, mother-centred services is matched by a simultaneous increased demand for obstetric intervention.

> "There's women who are choosing epidurals, a pain relief they wouldn't have chosen about ten years ago. In this hospital, it's very hi-tech for pain relief. More women are choosing to use that form of pain relief for labour so it is more expensive to assist them." (F Grade Midwife)

The view of a NDU midwife is that less analgesia and less intervention saves costs. "NDU must be a saving financially because it's very much low tech." Nevertheless, the reduction in the use of analgesia is related to an increase in the number of midwives.

> "I think if there was more one to one care and perhaps an increasing number of midwives, then people would use less analgesia."

Such a proposition is not popular with all maternity care practitioners, especially some senior midwives and most medical personnel.

The 'analgesia culture' seems to be acceptable by the average service user. Obstetric intervention is not always imposed on the user by the practitioner as is claimed by various pressure groups. Indeed, referring to caesarean sections, one consultant displayed her dissatisfaction with certain requests for this operation.

> "They think it's an easy option. They don't actually realise it's a major operation. There can be complications."

There is an acknowledged need to go ahead if there are sound clinical reasons. However, decisions are sometimes tempered by a fear of litigation.

On being asked whether she can think of ways in which offering choice could also prove to be cost-effective, the operational manager replied:

> " One of the ways we could reduce costs and improve choice for women is to stop the duplication of roles. We need midwives and obstetricians to provide a service but to do different things. We need midwives to look

> after normal cases. We should be looking after women as a team - with GPs being involved if they want to; with midwives being lead clinicians for normal pregnancy and labour and where necessary, bringing in consultants, obstetricians, neonatalogists, physios etc., where they're required on a needs basis - so that would be cutting down on duplication. Duplication costs a phenomenal amount of money. If you think about 6500 women per annum, and say about half of them are looked after by two health professionals doing the same thing, that's a huge amount of money."

*6.5.4 Service user choice and clinical governance*

Whilst the term 'clinical governance' was originally conceived as a system enabling health care practitioners to improve their performance through support and assistance, its implementation coincided with the performance management culture in vogue in the late nineties and during the present decade. Clinical governance, therefore, began to be perceived by analysts as an important aspect of NPM and as a system that seeks to monitor and measure clinical activity against externally imposed standards. Pollitt (1993) describes it as a form of management which is concerned with results, performance and outcomes. In the context of midwifery care, Pulzer (1999) describes clinical governance in more flexible terms. Clinical governance,

> "simply describes many activities that midwives are familiar with and already undertaking, for example, statutory supervisions, continuing professional development, clinical audit, risk management and standard setting."

Clinical governance needs to be backed up by evidence-based practice which according to Sackett et al. (1996:377) is the

> 'conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.'

One question put to participants is whether it is possible to reconcile patient choice with clinical governance and evidence-based medicine?

> "You have to find the balance. We're being pressurised from all sides now. Clinical governance (means) everybody will be responsible for what we're doing here. And people would just give a lot more thought to what we're doing and certainly medical and midwifery staff will have to work much closer together to achieve that."

One senior midwife pointed out that clinical governance and standard setting is not about process but about outcome. "They're not telling us *how* to achieve it." In other words a flexible approach is important.

> "Sometimes evidence-based is fine but sometimes we have a clinical feel for a situation and that can be argued is not something you can research unless it comes from long experience."

On the other hand, in some cases clinical strategies can be used to link up cost cutting and evidence-based medicine.

> "I think there is cost cutting even if it's a small thing like using water rather than buying in saline solutions or Savlon to wash somebody down and that's evidence-based."

*6.5.5 Continuity of care or care giver*

Service user choice and continuity of care are very intricately linked. When a service user is being looked after by a team of midwives and/or a named midwife it increases both the opportunity to discuss choice as well as enhance continuity of care/r. Indeed, holistic choice - the opportunity to discuss choices from the point of booking until after 28 days of delivery - goes hand in hand with continuity. Continuity and choice can be seen as part of the continuum of care. One midwife pointed out,

> "What units aim for is a high degree of continuity rather than full continuity. For full continuity a midwife has to be available 24/7 throughout woman's pregnancy, particularly during intrapartum period." (F Grade Midwife)

Whilst the quote above refers to continuity of carer, a high degree of continuity of care is deemed to be too onerous for midwives, most of whom have their own domestic responsibilities on top of their midwifery duties. The key ingredient, explained one NDU midwife is "very dedicated midwives and staff."

Continuity of care refers to a condition whereby the service user receives care by one or more practitioners who share a similar philosophy of care. Continuity of care giver refers to continual treatment by the same health care practitioner throughout an episode of care. Continuity of care usually refers to the whole period running

throughout the antenatal, intrapartum and postnatal episodes or, less typically, it could refer to continuity of carer within each of the three episodes of care.

A number of practitioners in this unit are resigned to the fact that within the present structures, service users may, at the very most, expect continuity of carer during the intrapartum period, but women are likely to see different midwives during the antenatal and postnatal periods. Continuity of carer during the intrapartum period is more likely to take place in the NDU as one midwife explains,

> "Continuity of care is when you have one midwife looking after you throughout your labour. At the moment we do twelve and a half hour shifts so you've got a good chance of being with somebody throughout their labour but you may pass on the 'patient' to one of the midwives but it's the sense that if that woman needs you, then you're there for her. You're not going to be taken to the operating theatre for somebody else, you're not going to be in the other room looking after somebody else at the same time which is the case in the (obstetric) labour ward a lot of the time. (Continuity of care) is the feeling that there's somebody there who could professionally support you." (F Grade NDU midwife)

Both caseload and team midwifery have been conceived with a view to improving continuity of care throughout the antenatal, postnatal and intrapartum periods. Since community midwifery is based on caseload and/or team midwifery, Crighton's planned midwifery system, is expected, in theory, to provide a service that is closer to the ideal form of care.

> "Continuity of care for me conjures up images of a friendly midwife who looks after a group of women who are pregnant who's professionally able to care for them and is there for them when they're needed - from the discovery of pregnancy through until a midwife attends a woman after the birth for ten days and up to 28 days - mostly for the ten days, but after the 28 days if need be." (NDU F Grade midwife)

In contrast, some midwives from the main ward informed that the obstetric unit is often too busy, short staffed and unpredictable to even allow for intrapartum continuity of carer.

> "It's not that anyone plans not to have continuity. It's circumstantial and it's because it's a big busy unit with lots of things going on."

Here, midwives are likely to be looking after several women simultaneously.

According to Enkin et al. (1990), improved continuity of care is not only preferred by women but that it can also reduce breast feeding problems and improve staff communication. About sixty years ago care was provided by the woman's own GP and the domiciliary midwife (RCM 1991). Within contemporary care systems, such as the one operating in Crighton, women receive fragmented and impersonal care.

> "A pregnant woman is likely to meet a GP, a consultant and several different midwives during her pregnancy, when she gives birth and during the postnatal period, some women may see as many as twelve professionals during this period" (RCM 1991).

Pilot studies, up and down the country, researching into continuity of care and carer have not been consistent in their results (Maternity Care Matters, 1998). Given that none of the schemes were identical in terms of their impacting variables, some were reported to be highly successful as well as costly whilst others were reported to have a high percentage of midwife 'burnout'. Stressful work patterns to ensure continuity of care meant, amongst other things, an infringement on the midwives' social and domestic lifestyles.

Several other factors seem to impede continuity for *all* users. In this maternity unit the complete transition to community midwifery had yet to be completed during fieldwork. Whilst community midwifery is more conducive to continuity of care/r than total care in the hospital setting, the debate about the best model of community midwifery still goes on. This debate is essentially focused on the balance of *choice* (for appropriate shift patterns) for the midwife against the users' *choice* (for integrated, consistent and continuous care). Whilst most, if not all midwives, are entirely in favour of the concept of continuity, many have extra-clinical roles to play and work patterns would therefore need to accommodate these considerations.

Nevertheless, community midwifery is still seen as the best system for improving continuity of care. The strategy to expand community midwifery is linked to raising standards of maternity care and improving continuity. One midwife thinks that,

> "In theory (continuity) should help the labour ward too, because if somebody's (community midwife) coming in with a woman in labour to look after them, you're not going to be so short staffed. Staff they already have (in hospital) will be people who are core staff." (F Grade Midwife)

Plans for continuity do require a generous staff to user ratio as well as logistic mastery because, whether the new community midwifery system will be an on-call or shift system, there can never be a guarantee of absolute continuity of *carer* by the named midwife.

### *6.5.6 Continuity of care and economic rationalism*

Continuity of care within a community team midwifery setting could reap a number of financial advantages.

(i) Duplication of work can be avoided

(ii) Unnecessary medical intervention can be avoided, particularly in situations where the service user receives professional support and care throughout the intrapartum episode (Hodnett 1994).

When the woman constantly faces new practitioners with whom she has had no time to build a relationship and who, consequently, do not have a sound picture of her preferences, she is apt to lose control over events. The results of a randomised trial undertaken in the mid 1980's concluded that *continuity of care* is beneficial in terms of psychosocial outcomes such as feeling more in control during labour and feeling more prepared for child care (Flint et al. 1989).

There seems to be wide disagreement as to the cost implications of implementing continuity of care. Spurgeon et al. (2001:126) maintain that,

> " ... continuous midwifery care throughout pregnancy and labour is resource intensive and demands high levels of flexibility, responsibility and commitment from midwives."

Like most economic evaluations of public services, it is very difficult to keep track of and anticipate the likely consequences on cost savings and outlay. On the face of it, effective continuity requires higher levels of staffing. On the other hand, one

midwife supposes,

> "Continuity of care in my mind would reduce the cost as well. I think it would because if a woman could have one to one care when she's in labour and she is being looked after by a midwife who wasn't feeling pressurised - if she was able to look after that woman completely ... giving her real choice and able to be there to support her, then you are going to cut down on your epidurals, you are going to cut down, therefore, on your caesarean sections and therefore forceps deliveries and the need for medical assistance - the need for anaesthetic or the need for pain relief. It's from what I've see." (G Grade NDU midwife).

This claim has been backed up by a number of studies, for example, Flint (1991), Hodnett 2001(a) and Hodnett 2001(b).

The raging debate about low cost, low-tech one to one midwifery care versus centralised obstetric care has been gaining ground in recent years. The spread of community midwifery, if properly directed, could lead to improved one to one care and possibly less intervention. However, this development also depends on the planned ward organisation of maternity units.

Is it more costly to have interventions carried out rather than employing more midwives who would be able to give one to one care? The answers lies in the choice of variables that are included in the costing, in particular key long term benefits and disadvantages which are included or excluded in the costing calculation.

Even if comparisons are measured and calculated over a number of years, the exercise may still yield imprecise results. High-risk pregnancies do tip the balance uncompromisingly in the obstetric direction. However, the choice of clinical setting remains a highly emotive issue,

> "maternity is one of the most emotive areas in health care and could be argued should not come under the umbrella of health care at all" (Hayden 1994).

and therefore, destined to remain in the political realm as much as in the economic one.

*6.5.7 Why economic rationalism is not the only factor impeding service user choice and continuity of care.*

The above evidence suggests that economic rationalism is responsible for a large part of the failure to maximise the implementation of continuity of care and service user choice. However, not all the findings fit in neatly within an NPM theoretical framework

*Firstly,* the exercise of choice is an interactive process. It can be restricted or broadened depending on who and how busy the practitioner is.

> "In theory they have choice, in practice it's very dependent on the people that they see from the minute they become pregnant and seek professional advice or guidance, whatever. I think it's very dependent on who you speak to as to what choice they actually get." (F Grade Midwife)

If the informer is a GP as well as a midwife, the service user may get two different versions of choices available. One participant explained that compared to an informed midwife, an uninformed GP may restrict the implementation of both service user choice and continuity of care.

> "They (GPs) may never have heard that they can see a midwife throughout the whole pregnancy. I would say a midwife is more likely to advise women about their choices but then again it depends who people speak to. In my experience nothing's explained about the choice to have a home birth, the choice to come to the Normal Delivery Unit or to go to the Obstetric Unit." (NDU F Grade midwife)

*Secondly,* the full and free exercise of *choice* is sometimes thwarted by issues of obstetric safety. Often presented as an absolute concept, safety is usually applied as a blanket term, apt to cover a multitude of issues. Safety of the woman and her child is often posited as a reason to bypass service user choice and to go ahead with obstetric intervention. Most healthy, low-risk women who are admitted to the main ward can easily get swept through a cascade of intervention: labour augmentation, epidural anaesthesia and double the risk of a caesarean section compared to non-interventionist approaches.

As Flynn (1999) points out, the idea that the Secretary of State for Health acting through a series of quangos, can determine in detail what will happen in every hospital in the country, implies a view of the health care process whereby hospitals are machines and clinicians are components and patients are raw materials which will respond to the health care process in a predictable and uniform way. Whilst new public management measures are having a significant impact on health care services, NPM is unable to manage the unpredictable human aspects of service provision. Nor has NPM diminished the collegial clout of the obstetric profession whose powerful influence clearly shapes both choices and outcomes for the service user.

## *6.6 Clinical communication, stress and the professions*

### *6.6.1 Clinical communication*

Underlying the notion of user choice policy is the assumption that communication amongst staff and service users is reasonable. When asked how well communication flows in this maternity unit, one participant assured me that communication flows very well between midwife and service user. After some hesitation, she stated that communication amongst colleagues is good as well. One midwife explained, "The medical staff don't always take as much time" as midwives to explain situations to service users. A discussion as to whether or not this tended to be a personality issue or whether it could be described as the general culture amongst medical staff ensued.

> "I suppose more of them (medical staff) communicate than don't. Some of them actually appear very rude and I'm sure they don't mean to but that's the way they come across because they don't communicate very well."

And does the gender of the medical practitioner make any difference in making communication more effective?

> "I think there is a difference but not as much as there should be. Women seem to be more understanding but they aren't always. I think possibly women who have had babies may be more understanding."

But as one community midwife pointed out, the extent of choice exercised and

communicated depends on the woman's "emotional baggage" - what she is willing or not willing to discuss. For example, a previous miscarriage or a violent relationship may influence her willingness to openly discuss her pregnancy and mode of delivery.

Another midwife explained the importance of the need for clear communication when responding to service user choice, emphasizing that service user choice is not about surrendering clinical expertise.

> "I think it needs to be more balanced. I still think we need to feel that women are here to discuss their care with us not to decide what their care is going to be from us. And we're not here to dictate what care we're going to give. It's a partnership and we need to discuss it. We need to find out their preferences, what their feelings are or their preferences - what we feel, in the present circumstances that particular woman is presently in, that she does not fully understand. We're in a position of having to explain to that woman and that she should expect us to explain it in a way that she understands. And if she doesn't understand it, maybe we're not explaining it correctly" (senior midwife).

She then pointed out that both heavy medical terminology and unclear pronunciation, on the clinician's part, could cause communication problems.

Effective communication requires parties to understand, if not accept, the complex underlying power structures. This applies to service users as much as it applies to the health practitioners themselves.

> "The relationship between client and clinician has been a major lever for change in the location of power. The service has moved away from obstetric-led to a more woman-centred package, including the introduction of multi-agency service[12]. There has been a clear though gradual change from consultant to midwife-led - so that women are referred from midwife to consultant" (senior midwife).

Senior midwives have regular meetings with their clinical managers. Referring to how complaints are dealt with, one newly appointed clinical manager explained that a four-hour meeting is held every three weeks.

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[12]Multi-agency services provide diverse frameworks of care in managing, for example, drug users. It is a system that taps into a whole range of agencies.

> "So the whole afternoon is taken up with issues we can discuss. And that's how we discuss those issues. We'll meet with other senior midwives where we air some complaints which are completely pertinent to that."

Vital information is then filtered down to the midwives individually or through their line manager. On being asked how the system ensures that vital information does reach key practitioners on the various shifts a senior midwife explained,

> "We're looking at the way communication is passed. We have already started a communications book for staff who've been away for a few days. They would be expected to read about the things that have changed since they were away and highlighted the things they must be aware of."

At the same time the same participant explained,

> "And the difficulty we have is releasing midwifery staff for getting into some of these meetings."

When the units are very busy, optimal communication may be lacking and may have an adverse impact on efficiency and effectiveness. One consultant explained some of the problems faced by midwives:

> "Generally, just to give you an example, a meeting takes place on a Friday at 8.30 in the morning to talk about problem babies and their obstetric management, quite a few midwives come to that. But a lot can't. The ones that start early can't; the ones that work on the labour ward can't. There are other meetings to look at abnormality babies, just to look at that and discuss their management and it's always felt that more midwives should come to that but they can't get off."

The above evidence means that low staffing resources impede good communication and information flows in a large and busy organization such as Crighton.

Clear communication lines between health care practitioners and service users are not always possible. The completion of a birth plan provides an opportunity to dispel any misunderstanding between clinician and service user. One midwife explains,

> "In my experience, most of the women do fill in a birth plan especially if it is their first baby. Some of them are very clear and have a lot of background knowledge about the choices they're making and others don't seem as clear" (G Grade midwife)

However, for the service user, such an opportunity to be heard does not necessarily reap the desired outcome. Within a very busy unit, not only does lack of time encroach upon good communication flows, it can also predetermine clinical outcomes. What most women ask for in their birth plan and what ultimately takes place could be quite different. Putting aside unforeseen emergencies, sheer expediency, such as the need to keep queuing women moving through the 'clinical conveyor birth', is another significant determining factor.

Communication from the Trust to clinicians was also criticized. For example, one NDU midwife saw similarities between the present anticipated move to the new hospital and her earlier experience of a move from a small unit to this larger one.

> "I feel that that transition could have been made much smoother if we had been kept informed or even asked what we thought about things. And I think if they had spoken to people at this level about what was the best way to do things and even now with the new hospital - if they talk to people at this level, it might give them insight into what they need and what they don't need. You get the impression that the decisions are made from somewhere up high."

A senior midwife posited similar views expressing a gap in communication. Referring to the public consultation then underway, she felt,

> "I think lip service is being paid to that consultation with staff who already work in this unit."

The method is which the policy makers' agendas were launched during the abovementioned public consultation is discussed at length in Chapter eight.

*6.6.2 Stress*

Changes in the NHS at large and the constant, structural, managerial and policy changes have taken their toll on staff.

> "I would say that stress has increased for staff because there were a number of changes in the past ten years." (F Grade Midwife)

One clinical manager explained how closure of smaller units and the consequent centralisation of maternity care services at Crighton has meant stress and uncertainty

for staff. She also pointed out that not all of the 1995 *Maternity Strategy* policies have, as yet, been put into practice in this unit.

According to one midwife, the merging of maternity services at Crighton have had an adverse effect on the clinical milieu.

> "In theory, large hospitals have better equipment but I think in centralising, we've lost out on having small, more local ... (like) the old fashioned GP unit where people felt that they weren't so much coming into hospital but more of a maternity hospital, rather than coming to a big complex. I think that is the disadvantage. We've lost that. Because of a high turnover, people are probably rushed through the clinics and parentcraft and labour ward and postnatally rushed out." (F Grade Midwife)

Whilst this comment does not include the quality of care received during the antenatal and postnatal episodes, it does however imply that, for many service users, this important event has to be rushed through irrespective of the birth-plan expectations that go beforehand.

Commenting on how stressful larger units are compared to smaller ones, one midwife explained,

> "I think it's really the volume of patients. There is a very high turnover and I think to give them all individualised care is very very difficult."

But the level of stress may vary depending on the ward.

> "I think labour ward is more stressful because of the nature of the job but I think postnatal care in the wards is also quite stressful because you've got to handle quite a large workload. I think it's stressful in a different sort of way. And I don't think antenatal is at all stressful." (E Grade Midwife)

Midwives who have experienced a move from a smaller unit to a large unit, such as Crighton, have been subjected to a particular kind of stress.

> "I would say possibly 60% of staff have gone through a closure of their unit and moved to another unit, meaning they came to me from (here the participant identified the two smaller units). That has caused a great deal of stress to a lot of people. And in my opinion, in my experience, staff take over a year to settle following a move like that. I certainly did, and I

had a lot of experience. Their unit where they once worked is being closed so we have to move them. And sometimes in certain circumstances they've had to change department they were used to work in, they've had to do a form of re-training, they've had to leave friends and familiar surroundings, familiar ways of working and really it has been exceptionally stressful." (G Grade midwife)

In response to questions relating to standards, any allusion to poor quality care or low standards is always attributed to low staffing levels as opposed to clinical proficiency per se. One consultant explained one of the reasons behind staff shortages.

> "What's happened is they shut these units and brought them all to the one site but not brought the staff with them. They've tried to over-rationalise and so it resulted in not bringing the staff in that we should have done" (consultant obstetrician).

Low staffing seems to be a major issue. Even when the unit requires extra hands to cover all eventualities, it still runs on a minimum number of practitioners. One consultant decried the low number of midwives.

> "Certainly with the midwives, definitely, I do think it is a problem. When I was up in ward 'X'[13], one of the postnatal wards, I just happened to pass through there looking for a patient. There were two phones ringing, there were buzzers going. There were visitors waiting to ask something. There was not a single member of staff in sight and clearly they were all rushed off their feet. It was desperately understaffed."

The worst scenario is when low staff-user ratios lead to stress that in turn lead to error and possibly litigation. Even given the best scenario, it does mean that standards are,

> "... low in comparison to the standards we're expected to achieve. You know you've got women coming in expecting one to one care. If you have staff to allow that, than you can meet the standard." (G Grade midwife)

Ironically the threat of litigation itself tends to make the clinical setting even more stressful.

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[13] Ward details are being omitted to retain anonymity.

"The highest proportion of law suits are made in obstetrics so I think that's quite stressful" (junior doctor).

Linked to clinical error, which may lead to litigation, are the increasingly high expectations of the user. Referring to demands placed on clinicians, one senior midwife felt,

"It's stressful in the practical sense. I think it's stressful in the sense that we have now accepted the higher standards."

Yet another source of stress is uncertainty. This is a key clinical characterisitic, which is not necessarily related to skill, competence and experience, but simply describes the nature of childbirth with its occasional unexpected developments and outcomes. It is not always possible to tell which seemingly normal pregnancy or labour will turn out to be a critical one. Unexpected emergencies are always possible so that practitioners work in an ambience of stress and uncertainty particularly in a large, busy and highly medicalised unit.

Changes in management structures, community midwifery systems, and parent education add to stress. One community midwifery leader sums it up.

"One is the increased workload. I'm talking about the community with the transfer of care out into the community; it's increased the workload out in the community. Also, there's been an increase in parent education. It's been transferred out into community as well. There's also been a lot of changes in the management structure within the Trust and that has caused staff stress."

In this maternity unit, as in many others across Scotland[14], the caesarean section rates are rising - a situation which adds to the demand for obstetric expertise. One consultant observed,

"The current caesarean section rate is approaching 20% and you need an obstetrician to do that. Now some of us believe that it's far too high and women themselves, some women themselves are demanding caesarean sections" (consultant obstetrician).

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[14] In Scotland, the elective caesarean rates have risen from 5.4% in 1990 to 7.2% in 1999. Emergency caesarean rates have also risen from 9.2% in 1990 to 12.5% in 1999. (ISD National Statistics)

But this demand in obstetric services does not necessarily correspond with an increase in the number of obstetricians available.

> "We have limited time available. We have to kind of prioritise. Because obstetricians are also often gynaecologists as well, we often have to prioritise. There's a limited amount of time and a limited number of sessions we can cover. So we have to prioritise and perhaps change the way that we carry out our jobs" (consultant obstetrician).

Stressful working conditions mean that there are an insufficient number of staff in proportion to the number of users, and hence no time for clinicians to discuss the pros and cons from conception right through to delivery.

> "Sometimes you know when somebody is about to have their baby, you can't go into big detail. You just say, 'well we haven't got time to discuss the pros and cons.' Choice will be enhanced if we have enough midwives for the number of pregnant women and it would also be enhanced if the antenatal visit lasts thirty rather than ten minutes." (Senior Registrar)

The policy of designating two midwives to one woman in the main ward hides the fact that there may still be several users being looked after by the same midwife. During busy periods, this would mean that each user is looked after by two busy midwives instead of one midwife who gives them total attention which is the case in the NDU.

At times the physical situation in the wards is such that both the obstetrician's better judgement and the agreed policies and procedures are forced to give way. An NDU midwife describes her past experience in the obstetric ward.

> "I think there was a few times when things came to a standstill ... because there was no beds left. There was a crisis a few times and they had an agreement at that time that they wouldn't induce people unless there was a medical reason or women had to be term plus ten. But some of them still do - the consultants still do. They still go ahead."

The difference in approach stems from pragmatic concerns.

> "I suppose part of the reason it (intervention) happens upstairs is because they're pushed for beds a lot of the time. There's all sorts of queuing and people waiting to come into labour ward. There is a need for

> the labour area to be reduced because of pressure on the beds. It becomes like a conveyor belt. When you're really busy and you don't have the number of midwives. You know you've got midwives who've not had a break." (F Grade NDU midwife)

From the user's point of view, these conditions mean that choice and continuity can never be guaranteed and that stress is exacerbated in units that have 'a conveyor-belt approach' to deliveries. One midwife from NDU described the main ward as having such an approach and drew a sharp distinction between high-tech and low-tech modes of delivery. In many cases, the type of ward itself brings about the self-fulfilment of expected outcomes.

The profuse range of values and priorities, the ambiguity of targets to be achieved and the requirement to integrate financial control, service performance and clinical quality can result in severe organisational stress. In search for greater efficiency, staff and skill levels, ward space and number of beds available are rationed. These economic imperatives impinge on the quality and standard of care, safety and user choice and ultimately high levels of stress have to be endured by practitioners.

> "There's a feeling amongst staff that we work on a bare minimum all the time. If we we're thinking of giving one-to-one care, technically we need one midwife to every single woman in this department. We'll never have that kind of staffing" (senior registrar).

One consultant illustrated the effects of low staffing levels in the main labour ward.

> "I think we're very very pushed for staff. I think if you look at the actual care of women in labour, there is much more tendency for women to be left on their own unattended during part of their labour - not because of neglect but because there's too much pressure."

The management of individual 'labours' is often directed by the aggregate management of 'labours' owing to bed, staff and, by implication, time shortage. The anxiety over low levels of staff spilled over into the practical realities of moving to the new site.

> "We're expected to send another group of midwives out into the community within the next 18 months - that's early next year as we reduce the bed usage here. But we're still not seeing a significant increase in the women who we are able to send home early. And I would

> have hoped that we are seeing that now with only 18 months to go. So that's why I'm worried about where we go from here" (senior midwife).

The concern being expressed here is related to the planned decrease in the number of maternity beds in the new hospital.

> "At moment we are often bursting at the seams with not having enough postnatal beds to the point of having the labour ward (as opposed to the postnatal ward) backed up with ladies who have delivered several hours ago none of whom are suitable to go home. And we're moving to a unit which is smaller and will not have the capacity to accommodate that. We'll be in the frontline of physically turfing people out in order to get space" (senior midwife).

### *6.6.3 The professional relationship*

Parallel to changes brought about by economic rationalism and the ensuing new public management strategies is a change in inter-professional relations as well as changes in service user attitudes towards their health care practitioners. Participants pointed out that nurses and midwives are becoming less complacent and more questioning than they used to be.

> "They're challenging, they're enquiring and again this is making our medical colleagues realise that no longer do they have the domain, the right to dictate. Certainly in this unit there's been a big shift in terms of how we work together." (Midwife Grade G)

Accepting that the unit need not to be medically-led and medically-driven, I asked the midwife when does it become necessary in an antenatal or intrapartum situation to bring in an obstetrician.

> "Anything that requires intervention needs an obstetrician. This may be at any stage during pregnancy. You need an obstetrician to carry out a lot of tests that women want antenatally or to discuss the interpretation of these tests such as detailed ultrasound scanning to look at the baby."

The changeover of service user care from midwife to obstetrician is not always as smooth as it might appear. It was suggested by both midwifery and medical participants that although some midwives are not prepared to leave the back seat, other nursing and midwifery staff are becoming more questioning and assertive

towards their medical colleagues. The practical reality is that not all medical practitioners are open to being challenged or at least to have some kind of dialogue with nursing and midwifery staff. One clinical manager explained,

> "I feel there should be much more collaborative discussion and debate and indeed the faculties in terms of medicine and nursing are poles apart and never should the twain meet."

Abbott (1998:2) explains that the control over care or treatment can bring the professions into conflict with each other because the control of knowledge and its application fuels "interprofessional competition."

A NDU midwife illustrated the jurisdictional challenges operating within Crighton. She pointed out that, in the main labour ward, medical involvement is universal and continuous.

> "Up in the labour ward, the doctors are very much aware of what's going on from the start and they're involved from the start."

Medical involvement may include care from an SHO, registrar or senior registrar and not necessarily a fully-fledged consultant obstetrician. She added that in the main labour ward the midwife is,

> "more likely to have to go along with the way the doctors want things to be, with the way obstetricians want things to be up there. If they're (labouring women) not progressing at a certain rate, they're more likely to have to interfere."

In contrast, in the NDU, where labour is totally midwife-led and midwife-managed, no interprofessional jurisdictional tensions exist. Coombes (2003) reported in the BMJ[15] how the CHI[16] found that poor work relationships between midwives and obstetricians can hamper care. One consultant at Crighton reported that whilst she feels at ease working side by side with midwives, she conceded that some consultant

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[15] British Medical Journal

16 Commissions for Health Improvement

obstetricians still resist "working together with midwifery and nursing, sort of, on an equal basis."

Whilst "jurisdictional boundaries are perpetually in dispute both in local practice and in national claims" (Abbott 1998), midwives at Crighton seemed to lack a unified voice on a number of maternity care issues and, therefore, fail to have sufficient clout to bring about any serious changes. One midwife complained,

> "Yes, you've got the patients' voice, patients' clout and the patients' rights. But what are the midwives' rights? Midwives probably all have different ideas."

Since they do no come across as a unified force they are unable to gain any political sway. Yet, despite midwives' apparent lack of influence as a group, senior midwives can be very effective in bringing about the needed changes when the right kind of leadership is required. Faced with reluctant hospital midwives lacking community skills and with community midwives needing to acquire hospital skills, one senior midwife informed,

> "One of our midwives has started herself. And we're all joining the bandwagon. One of our objectives is to twin up with the community team - both for getting the experience for going out into the community and for getting the community team in (to the hospital) to update their skills."

This is a good example of the sort of initiative that needs to be taken in order to make the expansion of community midwifery possible.

In highly medicalised units, midwives are often forced to abandon their expertise to obstetric intervention, and whilst they have not lost the service users' trust in their expertise, like other professions (McLaughlin et al. 2002), they are experiencing a decline of deference. The change in service user culture has changed both the clinical relationships and the delivery of care itself.

> "I mean the expectations from our clients has changed drastically. Informed consent is taken to a point of then challenging treatment and not agreeing and the impact that has on relationships and care delivery." (Midwife Grade G)

Similarly, the role of doctors vis a vis their patients has been increasingly exposed to critical scrutiny in recent years.

> "While the relationship has traditionally been marked by a deferential and uncritical attitude on the part of the patient, service users have begun to express greater concern over issues like variability in clinical practice, excessive waiting times for treatment and uncommunicative personal styles"(Harrison et al. 1992:102).

Medical expertise has a significant hold over health service users, yet it leaves a growing number who are questioning and dissatisfied.

### *6.7 Economic rationalism and cost consciousness*

Discussions with participants about cost efficiency raised two issues. One is their awareness of cost-cutting measures and the consequent effects on maternity provision. The other is their participation in cost-cutting measures – the requirement for a pro-active approach towards cost efficiency. Participants noted that, over the years, there have been drives to reduce costs that would have no adverse effects on the health of the mother and child. These included, for example, the removal of gowns worn during labour, cheaper disposable gloves, the substitution of water for Savlon, lower supplies in the stores and the transfer of the cost of nappies, breast pads and sanitary towels to the service user herself. Yet it was reported that such cost savings have not resulted in increased expenditure in other vital health care areas. The operational manager informed me that when she practised as a midwife, she made a substantial saving on costs when she initiated the substitution of water for Savlon.[17] Senior midwives, who work closely with clinical managers, similarly felt obliged to reduce overall costs and to keep a close eye on the use and abuse of resources. Overall, however, practitioners insisted that care was foremost and cost efficiency was left to someone else. Although the drive by the Trust to cultivate a

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17 Findings from a study by Sleep and Grant (1998) provide no support for routine use of either Savlon bath concentrate or salt in the management of post partum perineal discomfort, and raise questions about their usefulness in other nursing contexts. Authors conclude it is an unnecessary and costly procedure.

cost efficiency culture remains, the operational manager intimated that hardly any of her colleagues bother to take the initiative to cut costs. A Senior House Officer brushed aside questions concerning the waste of resources with reminders that maternity is a highly litigious field where cutting corners was simply out of the question.

One consultant explained that different philosophies in maternity care, particularly during labour, are apt to result in different levels of cost. One controversial area that divides practitioners is complementary and alternative therapies. Not only do practitioners range from ardent enthusiasts to hardened sceptics about this issue but, as can be expected, the former believe complementary and alternative medicine (CAM) can bring about cost savings whereas the latter believe CAM would only add to an already over-stretched budget. One community midwife leader asserted that CAM could cut down on costs.

> "If you have midwives trained (in CAM) and enough midwives to give them time allocated to do it within their midwifery hours - then you would save money."[18]

She argued that certain therapies should be practised by midwives because they are beneficial to the service user and are cost effective.

> "I would certainly think there would be a reduction in the cost if you're reducing anxiety, tension - then progress in labour is very very good. If you've got somebody who is not fully relaxed who is not focused on what's happening - that may be the reason why progress has not been made."

CAM sceptics, on the other hand, are likely to perceive training in CAM as an unnecessary drain on stretched resources. Since staff salaries are the largest outlay in any unit, staff training and retention is always under threat when a drive to save money is strong.

At the other extreme, one consultant advocated the use of more technology that

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18This view contrasts very sharply with that of the clinical director at Bingham. He perceives the whole venture of training staff in CAM as risky both financially and medically.

would cut down on costs proposing that the way forward is,

> " ... better, more efficient ways of screening and finding people who've got a problem and then the idea is that everybody else who's normal and healthy could have a sort of more low key approach to their care which should work out cheaper."

Marshall (1999) cast doubts that early screening and early diagnosis could cut health costs significantly.

Sometimes cost cutting is ingeniously concealed by some desirable strategy. The closing down of nurseries for normal babies, for example, meant a substantial saving in cash.

> "They took away the nurseries. Of course, the original reason for that was to bond the mum and the baby."

Answers to questions about cost and cost consciousness revealed that the financing of maternity care is divorced from the social health policy goals it seeks to attain. Financing health care is based purely on tangible costs and narrowly defined health benefits with very little direct reference to the costly business of measuring medium or long term outcomes for the service user. Within Crighton, service user choice and continuity of care do not seem to play a part in decisions about the way cash and other resources are allocated. At best, there may be an increase in the dissemination of maternity care information to spell out options to the service user. At worst, there are serious skill and staff shortages rendering the goals of service user choice and continuity of care even more difficult to attain.[19]

## *6.8 Summary*

In Crighton, the impact of economic rationalism on maternity services has meant a dramatic cut in staffing levels, a strategy achieved through the reduction of staff following the merging of small and medium sized units into a hyperunit. The impact

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[19]A number of participants commented about shortage of skills - particularly for future community midwives and a serious - if not dangerous - shortage of staff during very busy periods.

of NPM is reflected in the continual organisational restructuring of the unit and the appointment of new budget holders. The experience of the budget holding operational manager and five clinical managers was reported to be a negative one where red tape, excessive financial monitoring and lack of fiscal manoeuvrability lead to frustration rather than financial freedom.

Participants recounted how the provision of maternity care has changed over the years. Whilst the standards themselves are going up, staff resources seemed to be going down. The upward spiral towards higher expectations of better standards by the service user sometimes results in a no-win situation for both user and practitioner. Whilst fieldwork excluded the direct views and opinions of service users, interviews with maternity care practitioners indicate that the definition of quality and of health gain are largely imposed by health care practitioners leaving limited room for service user negotiation. These difficulties are offset by the planned change to community midwifery that promises better quality care for the service user.

Whilst an analysis of service user choice reveals its conceptual complexity, within a large, busy and highly medicalised unit, such as Crighton, service user choice is largely circumscribed by the clinical milieu. When it comes to choosing a model of best practice, both service user and health care practitioner adhere to contested maternity care cultures. With the principle of continuity of care, what differs amongst clinicians is the extent to which such a policy is feasible and the extent to which it is beneficial to the service user.

Findings reveal that economic rationalism has had a significant impact on the organisation and culture of maternity care provision. However, in Crighton, other factors such as the influence and authority of obstetricians also prevail. Apart from the Normal Delivery Unit, the overall picture which emerges is an ambience which is very busy and very stressful and where births are processed quickly ensuring medically approved outcomes.

# Chapter seven

## The centralisation of maternity services: an aspect of managerialism impacting on the two sites

### *7.1 Introduction*

The empirics in the two earlier chapters clearly suggest that to discuss the influence of ER/NPM[1] on maternity care provision, whilst ignoring the local and global trend towards the centralisation of services, is to miss its essential impact. Crighton, a hyperunit, is the product of a number of mergers whilst Bingham, the medium sized unit is, at the time of writing, in the process of merging with another medium sized unit to create a large maternity unit. As will be seen in the various discussions that follow, the centralisation of services is officially explained as an economically rational decision. Yet, such reorganisations leave a number of health care and economic inconsistencies in their trail.

The amalgamation of maternity services directly, and sometimes indirectly, contradicts the philosophy underlying *Changing Childbirth.* As this procedure is taking place nationwide, some of these findings lend a certain amount of generalisability. The chapter begins with an overview of maternity care provision in Scotland. It examines the parts played by midwifery care, obstetric management and technological innovation in shaping maternity care provision. The first part of the chapter serves as a backdrop to the discussion about ER/NPM and the centralisation of these services. The second part includes an outline of the proposed merger of

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[1] ER/NPM: Economic Rationalism/New Public Management

Bingham and Warnick, followed by a close examination of the five reasons which are usually put forward in various official documents as grounds for the centralisation of services. A reflection on the likely cost, service user satisfaction and health outcomes of large units compared to smaller ones precedes a discussion of the anomalies concerning such a reorganisation. Despite 'economy' and consumer sovereignty which underpin ER/NPM, such a centralised service is likely to turn out to be (i) more expensive in the short and long term (ii) less service user friendly than smaller low tech units and (iii) likely to carry health risks for the majority of women, infants and ultimately the general public.

## 7.2 A Scottish Overview

There were 52,682 live births in Scotland in 1999 – the lowest number recorded since civil registration was introduced in 1855 (GRO 2000). Compared to half a century ago or more, today, maternal mortality rates and deaths are rare. More babies that are premature survive and the infant mortality rate has been dramatically reduced. Different maternity service modes can be found in the various Scottish regions. The organisational style of the service is often linked to the size of the unit as well as to the midwifery system in place.

**Table 7.1 No of units and mean no of births in each category according to size and type of unit (2000)**

| | **Total** | **Small** | **Medium** | **Large** | **Hyper** |
|---|---|---|---|---|---|
| No of births | | (1-299) | (300-2999) | (3000 - 4999) | (5000-7000) |
| **Consultant Units (CU)** | 16 | 2 (mean 173) | 13 (mean 1662) ***Bingham*** | | 1 (6418) ***Crighton*** |
| **Combined Consultant and Midwife led units** | 5 | | 1 (2990) | 4 (mean 4138) | |
| **Midwife led unit (MLU)** | 8 | 8 (mean 35) | | | |
| **GP unit** | 13 | 13 (mean 55) | | | |
| **Total no of units** | 42 | 23 | 14 | 4 | 1 |

*Adapted form BirthChoice UK Statistics*[2]

[2] http://www.birthchoiceuk.com/Tables/Table40_Scot.htm 01/04/2002 BirthChoice statistics give only two unit size categories: large and small. The four categories in Table 7.1 are the writer's own grouping.

Scotland has 42 maternity units in total. Table 7.1 above, shows these units by type and size. There is only one hyperunit (5000 – 7000 births) and only one medium sized combined CU (consultant unit) / MLU (midwife led unit). The mean number of births in each size and category is shown in brackets.

**Table 7.2 Mode of delivery in Scotland**

| YEAR | 1990 | 1999 |
|---|---|---|
| No of live births | 63,351 | 52,682 |
| Spontaneous | 72.1% | 67.8% |
| Forceps | 11.2 | 6.8 |
| V.E.[3] | 1.2 | 5.1 |
| Breech | 1.0 | 0.6 |
| Elective Caesarean | 5.4 | 7.2 |
| Emergency Caesarean | 9.2 | 12.5 |
| **Total Caesarean** | **14.6** | **19.7** |
| Percentage induced | 21.1 | 27.1 |

*Adapted from ISD National Statistics*

Table 7.2 shows the mode of delivery across all maternity units in Scotland. The table does not list the number and extent of all obstetric and midwifery interventions. Comprehensive comparative statistics showing how all small units fare compared to larger ones are not available. BirthChoice statistics, however, do inform that out of the thirteen consultant units in Scotland, nine have:

100% unassisted delivery rate
0% for induction
0% for caesarean rate
0% for instrumental delivery.

All eight MLUs have:

100% unassisted delivery rate
0% instrumental delivery rate

[3] Vacuum Extraction

0% caesarean rate

and seven of them have 0% induction rate (BirthChoice UK 2002).

Whilst there is an indication that GP and MLU units are more likely to have low caesarean, induction and instrumental delivery rates, the numbers that do deliver in these small units are too low overall to indicate a clear statistical significance. Any vital comparative conclusions between large and small units can either be obtained through qualitative research or through quantitative research that takes into account a much broader framework of inquiry than data currently available on a national scale.

This study examines how maternity care is managed qualitatively within one consultant hyperunit and one medium-sized consultant unit. The issue of the diminution or augmentation of the quality of care as a result of the enlargement of maternity care organisations became more obviously significant as findings from the two sites were being compared and data analysed.

### *7.2.1 A brief analysis of managerialism in the provision of maternity care*

The new public management system is characterised by a series of organisational tensions such as the pressures of decentralisation and autonomy (such as the devolution of clinical budgets) on the one hand, and centralisation and control on the other. The practical realities concerning the merging of small and medium sized units into larger centralised units impact on the way staff are treated and managed, and in many ways reverses the rhetoric of devolved power. In theory, some of the advantages of decentralisation are local variation, local choice and the variety of techniques implemented to manage a revised set of services. In practice, the centralisation of maternity care units undoes local freedoms.

Policy makers' decision to close down many units nationwide, promoting the formation of fewer larger ones instead, is itself a centralist decision. These amalgamations are put forward as economically rational decisions bringing about economies of scale in a system which, it is claimed, cannot afford obstetric backing

within small midwifery-led units. The findings emerging from this and other studies question both the welfare aspect and the economic wisdom of this explanation.

ER/NPM elements, which feature in the provision of maternity care, are:

1. Services are controlled and monitored by narrow financial systems based on commercial accounting systems.

2. Units experience continual organisational restructuring and institutional turbulence

3. Low skill and low staffing levels inhibit customer sovereignty/service user choice.

However, findings reveal other key non-ER/NPM features which seriously impinge on the NPM debate.

1. Dependence on progressive technologies creates a need for fresh flows of cash

2. Traditional mechanistic approaches to the human body, related to point one above, exclude healthier, cost-effective, holistic alternatives.

### *7.3 The merging of maternity care provision: the rationale behind centralisation*

One combined economic and medical reason for the integration of units is that it allows medical practitioners to work together, putting them in a better position to attract new resources and expertise. The official argument is that such an arrangement guarantees that service users would have the very best in medical care when most needed in the setting where it can best be provided (Final Report of

Maternity Services Project Group[4] January 2000). This position was endorsed by Warnick's Directorate Manager.

> "The number of births we have does not justify two units, does not justify the estate that we are using with the two units. It gives us problems in terms of quality and does not support training posts. We don't have 24 hour cover for epidurals and that sort of thing."

National guidelines suggest that a minimum of 3000 annual live births is required to maintain a viable obstetric and neonatal unit. Owing to a falling birth rate, which is reducing the volume of activity, teaching and training are seen to be further compromised and, since directives on hours worked for junior medical staff are now more stringent, this difficulty is augmented. In addition, patients' expectations have risen with passing years, so that today, for example, babies born unexpectedly and prematurely are expected not only to survive but also to always do so unscathed. The input of senior medical staff both in the labour ward and in the Special Care Baby Unit (SBCU) is perceived as essential to such survival. Therefore, it has been argued that larger units are in a better position to meet the national recommendations and patient expectations (Maternity Services Advisory Group Report[5] 1997).

### *7.3.1 The merger of Bingham and Warnick maternity units*

At the time of conducting fieldwork for this study, the proposals for the merger of maternity and paediatric services of Bellham and Warnick were out for public consultation. The official assessment of the options to put to the public was undertaken by implementing a process called *decision conferencing*. This method uses brainstorming to identify evaluative criteria. The criteria selected were:

*clinical outcomes:* such as safety

*accessibility:* such as minimum travel

*affordability*: which would include avoiding duplication

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[4] The full title of this document is excluded from the bibliography to ensure anonymity.

[5] The full title of this document is excluded from the bibliography to ensure anonymity.

*improving services*: such as ensuring quality/clinical effectiveness.

These criteria are were sent out to various groups to analyse systematically what they consider to be the most important issues when deciding how and where best to provide maternity services. These groups comprised of health service staff, including doctors, nurses and midwives from both infirmaries; GPs, members of the public, and other patient representatives. Once the criteria were weighted and scored by those who participated in this exercise, the overall results were presented for appraisal. Results showed that quality/clinical effectiveness was deemed twice as important as affordability and accessibility was considered significantly more important than affordability. Overall, the agreed key evaluative criterion against which options were judged was clinical safety an unexamined concept which, according to various official merger publications such as *Proposals for Consultation* (2000) stresses the need for a high tech clinical environment and, therefore, excludes home births and non-medical deliveries.

On the face of it, this exercise seemed to carry validity and have wide approval. Ultimately, however, the selection of key evaluative criteria is open to manipulation by the powerful machinery that is driving the centralisation process forward. Brainstorming is neither necessarily democratic nor is it a scientific exercise. The questions put to the public and the substance of the agenda setters' justifications reflected an a priori decision to centralise services. It is not surprising, therefore, that clinical safety received the highest score.

Another important criterion is the geographical location of the maternity unit. A document entitled Preferred Location of Maternity and Paediatric Services[6] (2000) states that the location criteria aim at:

(i) maximising health gains for the population of that area based on relevant measures of health and service demand

(ii) ensuring the safety for mothers during delivery can be sustained

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[6] The full title of this document is excluded from the bibliography to ensure anonymity.

(iii) having healthier babies in future in that area.

On this basis it was decided that the in-patient elements of these services should be located in Bingham which has a greater concentration of socially deprived populations and where mothers and babies are more at risk. Again, an analysis of the population showed that the current and projected numbers of women in the 15-39-age range are higher in the Bingham area. This is also reflected in the higher number of births, both actual and projected in this area. Nevertheless, the accuracy of these figures have been disputed - with one participant claiming that figures were dated and based on the 1991 census.

According to the Maternity Services Advisory Group Report (1997), the provision of a dedicated obstetric anaesthetic service within the Bellham Trust catchment area would only be achievable when a fully comprehensive maternity service is provided on *one* inpatient site as opposed to two. The vast majority of the population live within thirty minutes travel time of both hospitals so that distance is not considered a significant factor. The long standing difficulties relating to emergency paediatric input which is lacking in Bingham is one key factor that has been used officially as the basis for a merger. At the same time, the existence of a fully equipped paediatric unit in Warnick did raise expectations that the new maternity unit would go to Warnick rather than Bingham.

In recent decades, there have been several merging maternity units throughout Scotland. Compared to half a century ago, or more, today maternal mortality rates and infant deaths are rare. More premature babies survive and the infant mortality rate has been dramatically reduced. Moreover, improved social conditions and public health have improved maternal health whilst the rapid development of new equipment and techniques have meant a shortened length of stay in hospital from ten days to 48 hours.

In response to a discussion of why a centralised unit is necessary when there is a vocal minority who desire to deliver in smaller, less medicalised units, one senior midwife argued strongly in favour of centralisation seeing it as the only feasible way of achieving maximum safety.

> "I mean a woman who wants the top, the highest level of expertise that she can get, and the highest level of expertise that a woman and a baby can get surely is in a centralised unit with everything there. It must be." (Senior Midwife)

It would seem that the desire for smaller dispersed units remains firmly out with the realms of *some* senior NHS staff thinking.

### *7.4 The amalgamation of maternity units: weighing up the official rationale in the light of Changing Childbirth*

The discussion that follows is based on the rationale found in various official documents[7] concerning (i) the merging of Bingham with Warnick (ii) the retention of Crighton as a hyperunit[8]. This section looks at what centralisation means, the arguments used by decision makers to support this model of maternity provision and its practical implications.

At a functional level, the centralisation of maternity services can be explained as the closing down of small or medium sized maternity units and their relocation within a large maternity unit within the same conurbation. Mergers often lead to a reduction in the overall number of beds and maternity care practitioners. Studies which demonstrate that merged services are likely to increase clinical stress and, therefore, unlikely to enhance the experience of pregnancy and childbirth are considered alongside the findings emerging from this study.

At a political level, the rationale behind centralisation is based on a number of disputed assertions:

(i) a decreasing birth rate

(ii) the need for medical safety not available in midwife led stand-alone units

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[7] Final Report of Maternity Services Project Group January 2000; Maternity. Achieving Change in Partnership Clinical Task Groups August 1999; Submission of Evidence in Response to the Consultation on the Future of Maternity Services (June 2000).

[8] Crighton is an amalgamation of four maternity units delivering between 6000-7000 births p.a.

(iii) the hospital's training role

(iv) to facilitate links between specialities and multidisciplinary teams

(v) to invest in advanced capital intensive technology not easily available to all units.

In this section, I would like to discuss each of the five assertions using official documentation, oral evidence collected during my in-depth interviews, statistical data and other secondary sources. Collected evidence is matched against the standards laid out in *Changing Childbirth,* in particular, the principle that places the needs of mothers and infants as a top priority.

### *7.4.1 Decreasing birth rate*

Recent demographic statistics show a decreasing birth rate in Scotland and the rest of the UK. However, there is no scientific basis for assuming that the birth rate will continue to drop in the future. The rate could just as easily increase. The logical link between centralisation and a decreasing birth rate is weak because an increase in the number of births could just as easily be used to justify the increased need for high-tech obstetric care that can be cost-effectively provided for in the larger unit. Not only is there no direct logical connection between a decreasing birth rate and the centralisation of services, but the effect of a decreasing birth rate on smaller units is likely to be less dramatic, if not negligible, compared to the overall effect.

Young (1994) maintains that the cost per case of small units can rise sharply if the number of deliveries falls. Opposing this view, Mugford (1990) warns that the continuing closure of small maternity units on grounds of rationalisation may merely represent a transfer of costs between sectors of the economy. For example, districts may lose resources that cannot be measured, as voluntary support for community hospitals cannot be transferred to the district hospital. Mugford suggests that better appraisal of options in maternity care may be facilitated by improved NHS accounting data when resource management initiatives are implemented.

It would seem that official documents make an issue of the decreasing birth rate without considering whether larger units are desirable and whether they will result in improved outcomes throughout pregnancy, delivery and beyond. Ultimately, the birth rate is an issue far removed from the pivotal concern outlined in *Changing Childbirth*; viz. the quality, rather than the quantity, of service provision.

### *7.4.2 The need for medical safety*

Clinical safety is a loaded concept. Whilst the perception of clinical safety holds a strong emotional appeal to many service users, midwives, and other health practitioners, the official recommendation of how clinical safety is best achieved is underlined by the supposition that national guidelines hold an error-proof authority on the best possible long-term outcomes of different modes of childbirth. In view of the position expressed by the National Childbirth Trust and other pressure groups, as well as the values highlighted in *Changing Childbirth*, it may be appropriate to examine the extent to which the requirement for high-tech obstetric care has more to do with technological advancement for its own sake and/or the creation and retention of one's medical status quo,[9] than with health promotion and the elimination of illness or complications. High technology complicates the birth process and both staff and service users suppose (or expediently accept) that certain clinical interventions are helpful or necessary.

Often presented as an absolute concept, medical safety is a blanket term covering a multitude of issues. For example, the risk of morbidity amongst women and their babies arising from the iatrogenic consequences posed by a high-tech institutional setting is often ignored. Hospitals are not necessarily the safest places to give birth after a normal pregnancy. This much is asserted in the Cumberledge Report[10] (1993). Since the majority of women are expected to experience normal childbirth, the majority do not require the services of a large centralised hospital. Thus, putting

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[9] High-tech obstetric care may also result from fears of litigation as explained in earlier chapters

[10] The titles Cumberledge Report and *Changing Childbirth* are used interchangeably throughout.

forward the medical safety argument as a basis for centralising services presumes that, rather than being natural processes, pregnancy and childbirth are potentially life-threatening conditions. Drawing from Campbell and Macfarlane (1966) and Tew (1990), Barkley and Barkley (1998:55) elucidates:

> "In all economically developed countries except Holland, maternity care has come to be organised so as to give full effect to the theory that childbirth is always safer if it takes place under the management of obstetricians in a hospital provided with the technological equipment for carrying out interventions in the natural process. It is a remarkable fact that obstetricians have never at any time had valid evidence to support the theory they have so successfully propagated. It was not based on the results of a randomised controlled trial for none was ever conducted; and once strong opinions have been implanted among both the providers and the users of the maternity service about its safer management, a randomised controlled trial had ceased to be a feasible or appropriate instrument for impartial evaluation."

Campbell and Macfarlane (1987) argue that the

> "... persistent and striking feature of the debate about where to be born ... is the way policy has been formed with very little reference to the evidence."

A 1991 report of an NCT survey maintains that the reason why consultant units are still used by most is that "most women are offered no choice about where and under whose care they may have their baby." Furthermore, Flint (1992) suggests that if all pregnant women are seen by an obstetrician, it is "more likely to assist junior doctors' training than benefit women." Consistent evidence as to what makes maternity care safe for normal pregnancies abounds. Young (1994:55), agreeing with Rosenblatt (1987), who examined a number of studies from Finland, Canada and New Zealand, suggests that, "outcomes for low-risk obstetric populations may be better in less technologically intensive settings."

Although normality comes in various guises, here it refers to childbirth without any medical intervention. One grass roots view comes with a multi dimensional approach towards safety during pregnancy and childbirth. McNeill (2000) explains that safety in childbirth

> "is the sum total of many contextual factors including – a woman's confidence, her underlying health, the confidence, competence and skill of the people around her, resources and equipment and how they are used, and not insignificantly the emotional environment – calm or panic, fear or confidence, urgency or relaxation, domination and control versus support and respect. They all have a bearing on safety."

In other words, the issue of safety also includes the cognitive, psychological, and emotional dimensions of both user and health professional.

The need to emphasise the *total* childbearing period (ante, intra and postpartum) can easily be overridden by outcome-focused obstetrics[11] that largely concerns itself with the intrapartum period. Often this approach is unlikely to take into account the woman's level of confidence and her emotional state or how well carers are able to support her (Green et al. 1988). The recognition of the mental and emotional processes during pregnancy and childbirth have been recognised as being as important as the clinical skills and experience of midwives and other practitioners. However, the influx and focus of a continual stream of trainees in large centralised hospitals is likely to deflect away from this central concern.

In ensuring medical safety, the relationship between staffing and efficiency is crucial. According to Eddy (2000), where there is full consultant cover on the labour ward, the chances of losing a full term baby are considerably reduced. Quoting Driffe (1999), Eddy informs us that only 1 in 15,000 babies die where there is full obstetric cover compared to 1 in 400 for a home delivery, 1 in 800 for a GP or midwifery unit and 1 in 1500 for a standard obstetric consultant unit in the UK. Even where infant deaths have been avoided, near misses can result in damaged babies. But Tew (1991) gives an entirely different picture of safety in childbirth. She assures that analysis of the 1986 national perinatal statistics from Holland show that mortality (for all births after 32 weeks gestation) is much lower under the non-interventionist care of

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[11] Findings in this study show that these obstetric approaches are not held exclusively by consultant obstetricians. Indeed, some seem to favour the natural approach (minimum intervention) though not necessarily the holistic (including the emotional and mental processes) approach to pregnancy and childbirth. Conversely, some midwives (or obstetric nurses) are inclined towards obstetric approaches to birth.

midwives than under the interventionist management of obstetricians at all levels of predicted risk. Furthermore, according to Barkley and Barkley (1998:55),

> "This finding confirms with great authority the conclusions of all earlier impartial analyses from Britain and other countries which agree in contradicting the claims on which the organisation of maternity services in most developed countries is now based, namely, that childbirth is made so much safer by application of high technology that only this option should be provided."

On the one hand, it can be argued that infant mortality is more likely to occur in situations where maternity care is not optimally managed owing to lack of a sufficient number of appropriately skilled clinicians - whether they are non-intervening midwives or intervening obstetricians. On the other, it can also be argued that in a system where a majority of service users prefer to hand over control to the practitioner, best results, as measured by infant mortality rates, are bound to be found in the high-tech and well-staffed obstetric units. Yet, Barkley and Barkley (1998) and Tew (1991) point out that high-tech intervention is not a key criterion for saving lives. Rather, there is a need for a structure that allows the service user to regain control over the physical and emotional aspects of childbirth so that the health practitioner (usually the midwife) would only be needed as facilitator giving optimum emotional support whilst the obstetrician takes over the small percentage of high-risk cases. Indeed, some midwife-managed units, such as the Edgeware Birth Centre, are able to care for 'low risk' woman without the assistance of obstetric or paediatric staff on site. A report about the Edgeware Birth Centre indicates that increasing the number of midwives to work in low cost midwife-managed units could prove more cost efficient than increasing the number of obstetricians in high-tech centralised units. Compared to the neighbouring Barnet hospital, maternity care costs at Edgeware Birth Centre are lower. This is likely to be due to

> " ... the relatively high proportion of women (in Barnet) receiving epidurals, who then go on to require a higher level of assisted labour on average, than women who use other forms of pain relief" (Saunders 2000:110).

Rather than providing small specialist units for high-risk pregnancies, the current trend is to make available large medicalised units for both high and low risk births

leaving only a few dispersed non-medical birthing centres run by midwives. The view that maternity units are too medicalised was put forward by Walsh and Newburn (2002) and endorsed by the NCT. According to Debbie Gould[12], a consultant midwife, "Women have to fit the system, a medically dominated system." A medicalised environment often lacks the personal approach and women's desire for a caesarean section has been linked to a culturally infused fear of childbirth. Mary Newburn[13] from NCT explains,

> "The culture in maternity units does not help women have a straightforward vaginal birth. We want to break the cycle and get birth out of the hospital environment because it can spoil the birth experience."

Obstetric backing is needed for a small percentage of high-risk users. However, if the same line of argument were to be used in relation to mental health for example, mental health services would need to be extended because, although this condition only affects a minority, anyone could potentially be placed in such a category. In brief, the medical safety argument is in danger of generating a self-fulfilling prophecy.

### *7.4.3 The hospital's training role*

Centralizing services into large training units means exposing medical and midwifery trainees to the maximum number of maternity cases. Concentrating trainees in such an environment is likely to result in an obstetric perspective of the labouring process where trainees learn that medical short cuts are more manageable than (if not more preferable to) normal deliveries. Acknowledging this situation, Lawrence Beech (2000) points out that "student midwives must learn and practise in an atmosphere that understands and enhances normality" - an opportunity denied in a large medicalised unit. Furthermore, by concentrating trainees in one place, service users are just as likely to be looked after by trainees as much as expertise. The supervision

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[12] See: http://www.nmc-uk.org/cms/content/News/Modern%20birth%too%20medical,%20 ... 23/08/2002

[13] Ibid

of a continuous stream of trainees is also likely to draw practitioners' attention away from their central role.

In recent years the health service has lost a high proportion of midwives. Out of the 92,000 registered midwives in the UK, about 63% (58,000) are not practicing midwives (AIMS; BRC; NCT; SIMS; June 2000[14]). Since there is no guarantee that midwives, doctors and consultants will stay in the health service, years of obstetric experience are not necessarily put into good use. Moreover, my observations in the larger unit indicate that senior staff (some senior management midwives and some consultant obstetricians in the larger units) who do retain their posts use much of their time performing tasks far removed from the delivery of babies. From this perspective, the centralisation of maternity units is a system that may be perceived as perpetuating the obstetric industry for its own sake using the medical safety and the obstetric training manifesto as a basis for expansion.

Lawrence Beech (2000) explains how women are,

> "being processed through a system which is designed to enable doctors to qualify and produce an endless stream of research papers that address issues of interest to doctors while ignoring research which is of value to women."

The conclusion from my own research is that the hyperunit with its concentration of trainees and advanced technological innovations is tantamount to creating vast orchards for a handful of apples, whilst an abundance of research findings points out that low-tech smaller units are likely to have better outcomes for the majority of pregnant women.

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[14] *Submission of Evidence for 'Craighill'Health in Response to the Consultation on the Future of Maternity Services* (June 2000) AIMS; BRC; NCT and SIMS in 'Craighill' Health Maternity Services in Appendix 5 Written Comments Received Throughout Public Consultation Process April 2000-June 2000

*7.4.4 To facilitate links between specialities and multidisciplinary teams*

Since instant communication systems and new technologies permit, medical, strategic and operational changes to take place swiftly and on a grand scale, multidisciplinary teams do not necessarily need to be under the same roof in order to forge common goals. Ultimately, creating increasingly larger hospitals in order to facilitate links between speciality and multidisciplinary teams may be a decision that is far removed from the kind of maternity care recommended in the Cumberledge Report (1993). Moreover, the search for a joint language and common objectives can easily take the whole venture to a totally different enterprise - one that may be is distanced from essential pregnancy and childbirth.

In principle, the opportunity to facilitate links between specialities and multidisciplinary teams sounds beneficial. In practice, the larger the unit, the more dispersed communication, continuity and co-ordination are likely to become for the service user. This study shows that grouping midwives into small teams and attaching each group to one consultant obstetrician (as is the case at Bingham) is conducive to effective communication, continuity and co-operation. Indeed, one midwife pointed out that the merger of Bingham with Warnick is likely to bring in an increasing variety of obstetric approaches.

> "It's bad enough with four consultants who may do things all just slightly different but when another four consultants[15] come in, you're talking about eight consultants there, and it might be eight totally different ...(approaches)." (Midwife, Bingham)

It would seem that the larger the unit, the bigger the threat to continuity and to efforts to bring about a smooth communication system - thus going against the general grain of *Changing Childbirth.*

During fieldwork, it was evident that Crighton potentially harbours more conflicting clinical advice for the service user than Bingham. Within the walls of a large

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[15] Referring to the four consultant obstetricians at Warnick

maternity unit, the practitioner, just like the service user, tends to lose his or her individual worth. For this reason, large institutions are more likely to breed a culture of individualism where dissension and fragmentation live and grow and where a unity of purpose and a collective ethos are likely to be missing. Clinical governance is meant to address, inter alia, conflicting methods of treatment but findings, such as the quote above, indicate that within a large organisation, the chances of coordinating philosophies (whether or not they are backed up by official protocol) is likely to be a very difficult task.

### 7.4.5 *To invest in advanced capital intensive technology not easily available to all units*

The trend towards the technologicisation of births began with the drop in the proportion of domiciliary births.

> "At the start of the 20th century, 99% of British babies were born at home. By the 1980s, the rate had dropped to less than 1%. Nowadays the rate is a little higher - 2.2% at the end of the 1990s (Horn 2004).

According to *Maternity Services in Scotland* (1959), home births dropped from 39% to 29% between 1949 and 1957 even though, at the time, the cost of a home confinement was less than that of a hospital in 1957.

The investment-in-advanced-capital-intensive-technology argument overrides existing evidence that low-tech units have been known to deliver successfully and satisfactorily. The presumption underlying some public documents is that intensive technology needs to be available in all maternity units and that most service users feel safer for it. In Scotland, the record to date is an increased use of ultrasound, induction of labour, and caesarean section (SNAP 1994). Table 7.3 shows how, according to *Health in Scotland* (1998), the percentages of some modes of delivery have changed between 1989 and 1998.

**Table 7.3 Changes in birth modes 1989-1998**

| | 1989(%) | 1998(%) |
|---|---|---|
| Spontaneous births | 72.7 | decreasing to 69.3 |
| Forceps | 11.1 | decreasing to 7.2 |
| Vacuum Extraction | 0.8 | increasing to 4.3 |
| Breech | 1.0 | decreasing to 0.6 |
| Caesarean section | 14.4 | increasing to 18.5 |
| Induced births | 20.4 | increasing to 25.4 |

*Adapted from Health Dept. Scottish Executive 1998*

One important positive aspect reported by SNAP (1994) is the increased survival of low birth weight babies and a drop in perinatal mortality rates. Does such evidence, however, convince that there is a need to expose *all* service users to large centralised high-tech units? Young (1994:55) points out that evidence from the Netherlands casts "major doubts about the justification for the British policy of centralisation which is, however, shared by all other developed countries." Young insists that place of birth does not have a significant impact on perinatal mortality and that most perinatal deaths are due to: i. congenital malformation ii. pre-term birth iii. unexplained death before labour (IUD). The centralisation of maternity care may be partly based on the Schumpeterian hypothesis that the large firm operating in a concentrated market is the main engine of technological progress. Unfortunately, in the case of maternity units, 'firm size' and innovation may not mean progress in terms of service users' overall health.

Whilst certain technologies are leading, rather than following, human health needs, public documents seem to endorse this approach. For example, in defence of centralisation and increased technological innovation, the Acute Services Strategy states,

> "It is becoming increasingly difficult to sustain this duplication of service (referring to maternity services), as is evident through the difficulties

> being experienced in recruiting to some specialist posts. Furthermore, there is a continuing need to invest in technologies, specialised medical equipment and physical accommodation" (2000: 8)[16].

Technology, whether it is high or low, does not change the physiological process of childbirth but it does alter the way it is experienced. Put another way,

> "...new technologies (and new organisational imperatives) alter not only the way in which the service product is delivered, they alter what the service product is." (Combes and Green 1992:294)

Yet investing in expensive and advanced technological equipment does not necessarily serve the *essential* needs of the majority of service users. Maternity care needs may be satisfactorily served in midwifery-led units. Various studies, Rooks et al. (1992), Walsh (2000) and Rosser (2001) found that lower intervention rates are associated both with midwifery-led care and birth taking place outside a consultant unit.

The Acute Services Strategy report goes on to give a list of conflicting reasons why there is a need to merge two maternity units onto one site. For example, "to determine the effectiveness of clinical services " on the one hand and "to respond to changing trends in care provision as a result of changing medical technology, clinical practice, and improvement in drug treatments" on the other, implies an a priori understanding of what clinical effectiveness entails. A bias favouring the purchase of newer technologies in health care is implicit in many official documents, whilst the effectiveness of old technologies is not acknowledged.

Various policy documents argue that the merger of Bingham and Warnick will reduce the unnecessary duplication of many services on each site. Yet, the rebuilding and extension of the maternity unit at Bingham will also prove very costly. The solution of retaining one of the units as a stand-alone midwife unit for the majority of users was not even put forward as an option. The debate is as much about new technologies as it is about the management, as opposed to the facilitation, of births.

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[16] The title of this document, which reveals the Trust's identity, is omitted from the bibliography.

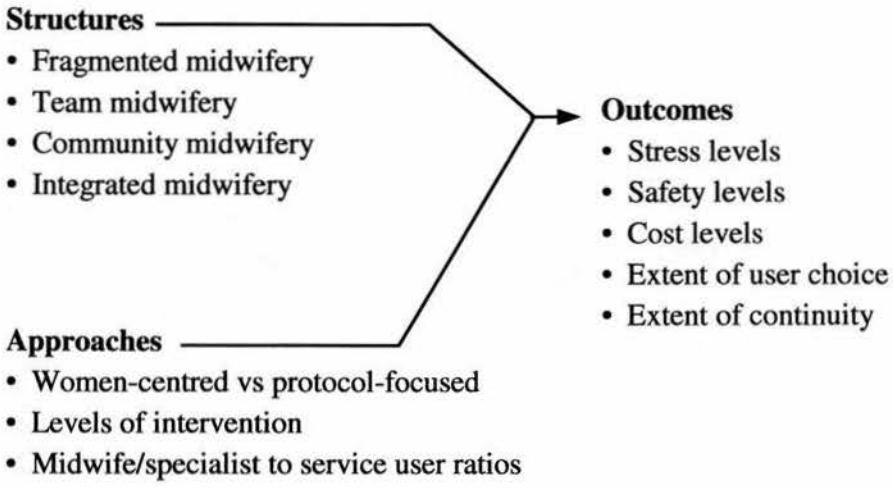
Conversely, the Cumberledge Report (1993) highlights the value of service user control over the birth process. Purkiss (1998) maintains that technology increases the knowledge and expertise of midwives assisting them to *manage* births at the expense of midwife facilitative support and human interaction. Moreover, midwives are taking on an increasingly technologically orientated role to compete with medical personnel (ibid 1998).

Pusey's (1991:200) critique of economic rationalism can be aptly applied to the race for newer and higher technologies wherein this trend "obeys not an immanent logic of needs, but instead the needs of an immanent logic ... the immanent knowledge is purely cybernetic." When technology rather the human experience leads the way, the dangers, which may result from caesarean sections and other obstetric interventions, go backstage.

### *7.5 Centralisation issues: structure, approaches and outcomes according to unit size*

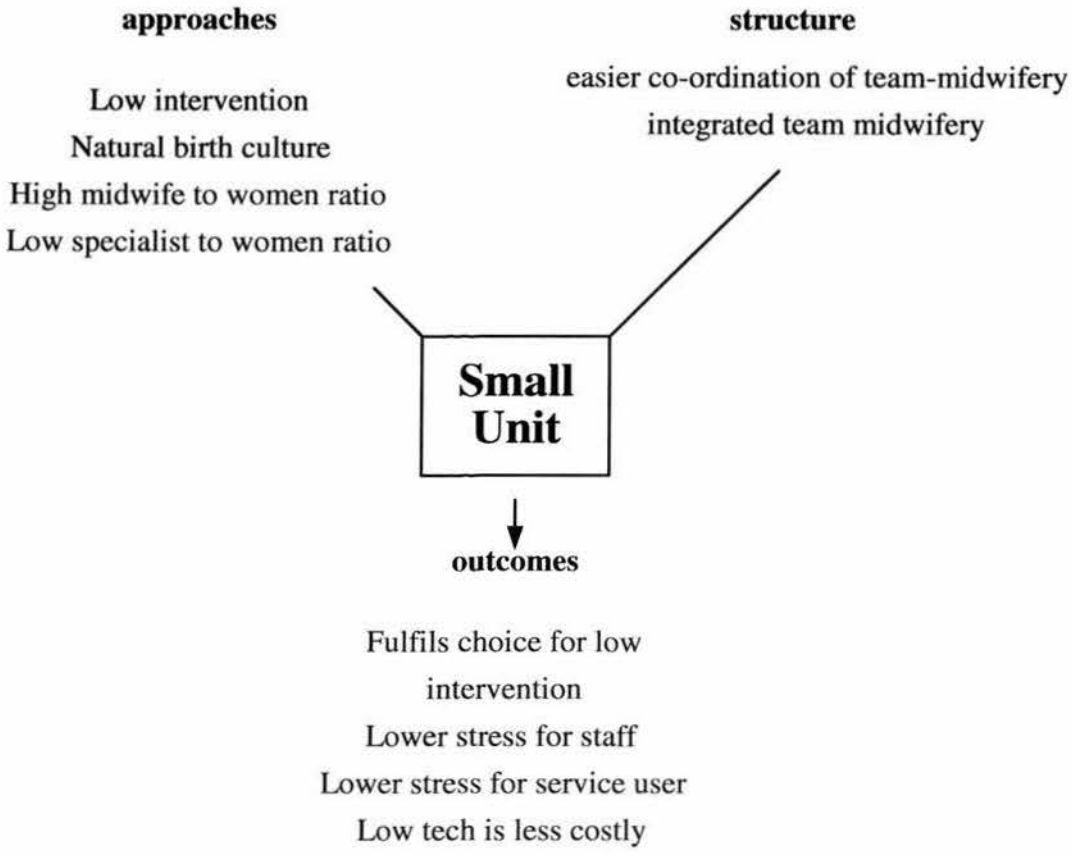
In contradistinction to the official rationale that purports the importance of clinical safety, the efficacy of small, medium and large maternity units can be approached from the quality-of-service perspective proposed by *Changing Childbirth*. Evidence collected from this and other studies suggests that clinical approaches and existing staffing structures, such as the midwifery systems in place, can have an important impact on levels of stress, clinical safety, cost, service user choice, and degrees of continuity. Figure 7.1 illustrates the relationship between these factors.

**Figure 7.1 Clinical structures, approaches and outcomes**



Although clinical structures and approaches are matters of tradition rather than unit size, this study strongly suggests that unit size is an important variable that accounts for desirable or undesirable outcomes. Indeed, Crighton itself houses two distinct cultures: the woman-centred approach in the three-bedded NDU and the medicalised approach in the large main ward. In large maternity units, the tendency is to put the needs of trainee midwives and doctors before the needs of the service user so that resources are more likely to be student-focused than women-centred. Figure 7.2 (small unit) and 7.3 (large unit) illustrate how distinct clinical structures and approaches can modify outcomes.

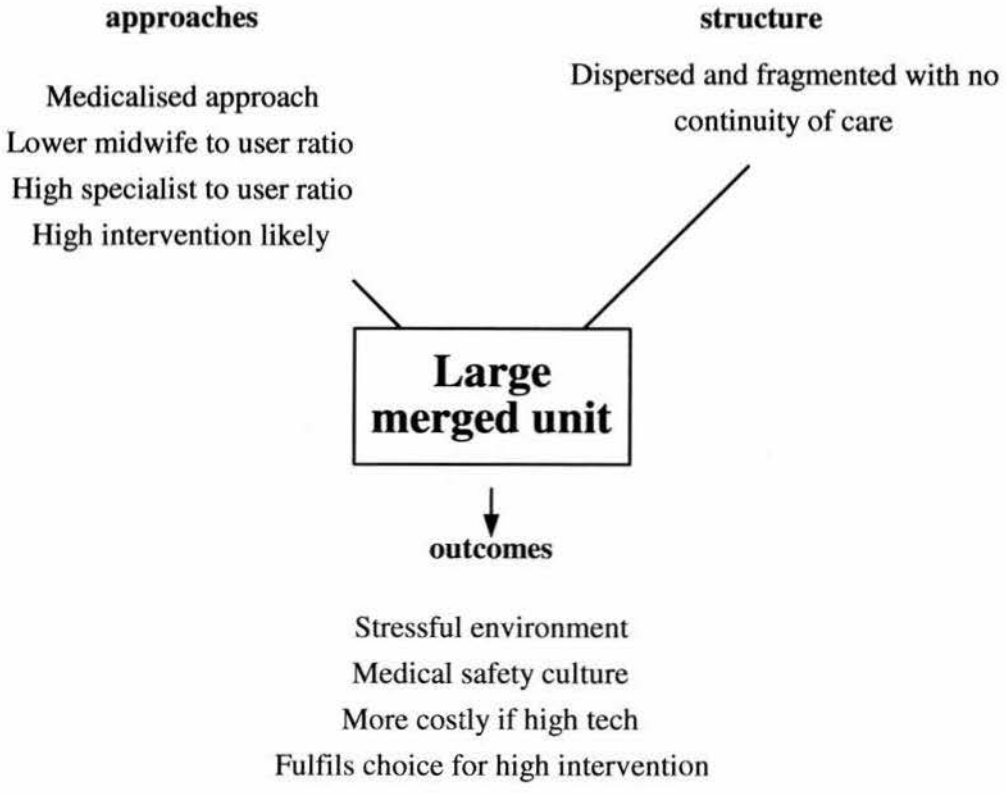
**Figure 7.2 Quality outcomes of small unit**




Although Figures 7.2 and 7.3 illustrate a highly generalised comparison outlining a variety of possible approaches, they demonstrate the experienced end-result of merging units (as illustrated by Crighton at the time of fieldwork) within the current rational economic framework. Centralisation is a recent national trend affecting most

maternity units including the two research sites. Crighton is a conglomeration of merged units whilst Bingham, at the time of writing, is in the process of merging with Warnick.

**Figure 7.3 Quality outcomes of large merged unit**




The structure of Bingham, the smaller unit under study, with its coordinated team midwifery resulting in a reasonable degree of continuity of care and lower medical practitioner to user ratio[17] is a place where service users are less likely to be exposed to medical intervention. As a result, the birth experience here is likely to be less stressful, given, inter alia, that service users are expected to be already acquainted with their practitioners. Conversely, Crighton, the larger unit under study, provides a dispersed and fragmented provision with no (or very low) continuity of care for the

[17] See Table 8.4

service user. With a higher medical practitioner to service user ratio[18], and a medicalised approach overall, obstetric intervention is very likely. Ultimately, a large unit like Crighton, where the high-tech and medical safety culture prevail, is likely to be a stressful environment.

### *7.5.1 Continuity of care and size of unit*

> "Small teams providing continuity of both care and care-giver throughout pregnancy during and after birth, enabling women to receive care from someone they know, has been shown to improve outcomes and increase satisfaction for women (Flint et al. 1989; Rowley, 1993; and Kenny et al.1994). In summary, shared care is acceptable to the consumer and provider, efficient and economic for the funder, and an effective form of care." NHMRC (1996:21)

In Bingham, maternity care is said to be 'practitioner-led', 'patient-focused' and 'protocol-driven'. In contrast, observations and the spirit of comments collected in Crighton suggest that this unit is less likely to be 'patient focused' or 'woman centred' and the main obstetric ward is largely medically driven. The admission that it is not always possible to provide a woman-centred service came more easily from Crighton than from Bingham. Anecdotal evidence about any shortcomings at Bingham were more likely to come from the neighbouring Warnick participants, whilst criticism of the main obstetric ward at Crighton came from the ward itself and especially from the NDU midwives. Both Crighton and Bingham have a high proportion of midwife led cases (over 75% in Bingham and over 60% in Crighton). However, these statistics hide different definitions of midwife led approaches. In view of the acknowledgment that, more recently, some midwives have taken over some of the junior doctors' role, these figures do not reveal the extent of midwifery intervention – a concept loaded with variant meanings. Midwives are able to carry out wide ranging tasks that may not necessarily be low tech. Thus, midwife-led deliveries do not always signify unassisted spontaneous births especially when midwives who perceive themselves, more appropriately, as obstetric nurses attend these births.

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[18] See Table 8.4

Crighton itself harbours two distinct maternity care cultures. The way childbirth is experienced within the NDU is vastly different from the way it is experienced in the main labour ward. The case for enlarging the NDU so as to remove the vicious circle of obstetric intervention is usually pitted against the case for the need to have a large obstetric unit so that midwifery and medical students can be exposed to the maximum variety of maternity cases. Whilst it can be argued that the merging of units is meant to result in economies of scale, there is an equally strong case for the reduction in high-tech obstetric care and an increase in low tech midwifery care, which is less costly because it avoids the services of medically qualified staff and, therefore, reduces the need for expensive drugs and equipment, notwithstanding the need for safety measures for high-risk pregnancies.

Participants at Bingham expressed their concern that the present degree of continuity could be disrupted when Bingham and Warnick merge. Apart from the influx of a number of unfamiliar faces, a merged larger unit may be less conducive to continuity of care whichever way this concept is defined. It would seem that one key tool for implementing continuity is organisational structure, for example, team midwifery combined with integrated care. However, for continuity of care to be successful, it needs to be provided by healthcare practitioners who share a similar philosophy, a feature that is more likely to be found in the smaller unit. Ultimately, however, whatever the size of the unit, adequate staffing levels is key to the provisions of continuity of care.

A larger unit:

- Decreases degree of democracy and lines of communication
- Increases the likelihood of anonymity of medical staff, trainees and other unfamiliar faces
- Reduces the likelihood that the service user will receive continuity of care which is underlined by a shared philosophy

- May manage to organize midwives into small cohesive teams, but a shared team philosophy may not take top priority. Other factors such as skill mix and where the midwife lives can play an important part in drawing up teams

- May increase likelihood of higher staff turnover and therefore disrupt the close ties needed to make team midwifery viable

- Increases the distance between management and team midwife owing to an expanded hierarchy

- Is likely to make the overall co-ordination, for example, of fourteen teams an arduous task. (The Bingham seven team midwifery system took about four years to establish and stabilise).

- Is likely to be more medicalised than the smaller unit. In the larger units, some midwives are more likely to take on the role of junior doctors so that the term 'midwife led' may not be entirely devoid of medical intervention.

Findings from the two sites point out that success in putting social health policies into practice is closely linked to the overall size of the unit. Whilst a small or medium-sized unit does not necessarily ensure the successful implementation of social health policies, the larger the unit the more difficult it becomes to implement and co-ordinate such policies.

It has been argued that smaller units and home births reduce both morbidity and mortality (Weigers et al.1996). Findings from this study clearly show that the bigger the unit, the less likely it is for the user to receive the kind of safety described by McNeill (2000)[19]. Practitioners in the larger unit spoke about high levels of stress and risk taking whereas the smaller unit had a more relaxed ambience. This was reflected in the way participants described their activities. Whilst the smaller unit does not fulfil all of McNeill's criteria of safety, it is able to fulfil some of them, in particular a calmer and more relaxed environment where total midwifery care is

[19] See earlier quote in section 7.4. 2

possible for more than 75% of its users. Conversely, Crighton's NDU comes very close to McNeill's description of safety. However, this sub-unit caters for less than 3% of women who use Crighton. A study by Ashcroft et al. (2003) supports these findings. The researchers found that a shortfall of midwives existed in all seven maternity units under study and that it was most acute in the largest units, adding that the system cannot operate safely and effectively when the number of midwives is inadequate.

Large centralised units are likely to be dominated by obstetric specialists and many, if not most, service users are exposed to the attention of medical practitioners. Whereas in the smaller unit, it is the midwife who is likely to decide if and when obstetric expertise is required, thus minimising the likelihood of fragmented specialist involvement. Figure 7.4, below, projected from my findings, indicates the two ends of the spectrum: the links between the size of unit and quality outcomes for both service user and practitioner.

**Figure 7.4 Unit size, and quality outcomes**

| Unit Size | Organisational mode | User experience | Practitioner experience |
|---|---|---|---|
| Small | Generic to specialist | Continuity of care | Support and co-ordination<br>Shared values |
| Large | Plethora of medical and midwifery specialists | Fragmentation and discontinuity | Multiple/conflicting philosophies<br>Various levels of funding/budget-holding |

Selected findings from fieldwork at Bingham highlighted how its integrated team midwifery system is closely linked to its size and organisational structure. With a

higher midwife to service user ratio, this unit tends to be more woman-centred and less stressful for both service users and practitioners than Crighton.

*7.5 2 Some of the disadvantages of large maternity units*

One survey *Women's views of Maternity Services in Craighill (2000[20])* conducted for Craighill Health Board, showed that large obstetric units are not popular with women. The centralised unit is more likely to provide routine and less personalised care. My own observations confirm that in the larger unit, the personal identity of both midwives and service users is lost. Owing to these elements of anonymity, budgetary constraints can more easily override the quality of care given by health care practitioners and internal hospital policies are less likely to be shaped by the needs and wishes of women and their families. Oral evidence suggests that owing to fragmented services, heavy workloads and ensuing stress, childbirth becomes a relatively de-humanised event. In smaller units, such as Bingham, deliveries are less prone to be rushed and streamlined through a series of obstetric measures.

The large unit under study was not conducive to continuity of care as practitioners tend to a number of service users simultaneously. Its organisational hierarchy creates a distance between clinician and service user that can prove detrimental when the need for attention is urgent. Similarly, the prospect of amalgamating Bingham and Warnick threatens to disrupt the moderate level of continuity of care prevalent in Bingham, because a larger unit is less likely to provide continuity of care unless the existing team midwifery model with a low to medium caseload is retained. A study by Allen et al. (1997), which compares three maternity units, shows that the smaller the caseload, the more likely it is for women to not only receive continuity of care, but to have their named midwife during labour and delivery *as well.* Crighton's conveyor belt approach to childbirth is a state of affairs which contrasts very sharply with its own three-bedded Normal Delivery Unit. In Crighton, normal childbirth is seriously and paradoxically marginalized.

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[20] The full title of this report has been changed to preserve anonymity

Distance is not just a feature of internal politics. For the non-local service user, large centralised units will involve more travel to and from the unit during pregnancy and labour. Distance also involves extra cost and inconvenience after birth for the service user. In the Crighton area for example, it is estimated that 30% to 40% of households do not have a car (*Report on New Maternity Services* 1994).

In a technologically, socially and economically changing world, the argument that 'greater volume leads to better outcomes' is not necessarily valid in the case of maternity care provision. McKee and Healy (2002:8) point out that existing research provides "little support for concentrating care in very large hospitals, on grounds of either efficiency or effectiveness." If the maternity setting can be understood as the lifeworld in the Habermasian sense (Habermas 1979), its permanence and coherence have been threatened by the colonisation of economic and obstetric agencies. In accordance with Habermas' theory, centralisation can be understood as a colonisation of services upsetting the life experiences, beliefs, and demands of the lifeworld and leading to systems getting out of hand and original values turning on their head as obstetric pathologies become the norm.

### *7.5.3 The contraindications of centralisation*

Health practitioners who participated in this study spoke of the lack of proper consultation before the decision to go ahead with centralisation plans. Closures of local maternity units and mergers went ahead despite opposition from service users and some health practitioners, particularly midwives. One midwife in Crighton reflected on the mandatory move to Crighton from a smaller unit, now closed down:

> "I feel that the transition could have been made much smoother if we had been kept informed or even asked what we thought about things. And I think if they had spoken to people on this level about what was the best way to do things and even now with the new hospital – if they talk to people at this level, it might give them insight into what they need and what they don't need. You get the impression that the decisions are made from someone up high".

The impression gained from my attendance at Open Hearings and from oral evidence given by some health care practitioners is that such public consultations are speeded

up and presented to the public with a decided bias in favour of a predetermined plan; viz. in favour of centralised services within high tech units. Apart from being a superficial public relations exercise, Open Hearings do reveal the nature of the suppressed disagreement between service users and policy makers. Even when disagreement is widespread, it is subtly pre-designated as a minority voice during public consultations. Whilst the standpoint coming from the grass roots appeals strongly to common sense considerations and often makes sound economic suggestions with satisfactory solutions, the agenda-setters approach maternity care from a vantage point which bears little or no relation to the actual experience of pregnancy and childbirth. The policy makers' focus on worst-case scenarios with its accompanying culture of fear directly opposes a constructive culture of positive care and support during this episode of the life of a woman and her family.

Writing from an Australian perspective Pusey's (1991:11) reflections on economic rationalism apply to any state-imposed culture within the public services.

> "What wins is a kind of 'dephenomenalising' abstraction that tries to neutralize the social contexts of program goals in every area, whether it be education, industry support, public health, or water resources management. What counts, further, is the speed, elegance, and agility with which one can create a purely formal and transcontextual commensurability of reference across goals that are then treated as the objects of decisions that will be made on extrinsic criteria even further removed from real tasks and situations."

An analysis of official merger and centralisation documents indicate that they are not written in a persuasive vein but in a style that ascertains that, the official recommendation is the only sane choice. The *Draft Initial Agreement* of the *Acute Services Strategy* (2000) includes a formula that comprises narrow medical and economic criteria for deciding whether or not to maintain centralised maternity care services. The document sets out six options with each option being given an arbitrary numerical score for each factor such as access, affordability and quality such as clinical effectiveness. Option 4 (centralising all existing inpatient services on a single site) not surprisingly gets the highest score. This formula, which is used throughout the document, overrides many important issues central to this service, such as the psychological needs and *real* choices of the service users.

Whilst Pusey (1991:10) maintains that "the state apparatus is caught within projections of reality that give primacy to 'the economy', second place to the political order, and third place to the social order", this assertion does not apply entirely to maternity care provision. Accepting that society has been recast as the object, rather than the subject, of politics (ibid 1991), the move to centralise maternity services suggests that the state apparatus is just as clearly caught up with the dictates of economic rationalism as it is with the dictates of a medical hegemony. Economic efficiency is put forward as the reason for not equipping small and medium-sized maternity units with the latest, and supposedly most progressive obstetric technologies. However, the underlying presumption is that the latter are both more desirable and safer for the service users. Thus, the need for economic restraint becomes an artificially created consideration following the unquestioned presumption that high tech is a necessary element of maternity care provision and that only the latest technologies can save lives.

The foregoing evidence suggests that centralisation can be understood as the dismantling of small and successfully run maternity units where evidence of service user satisfaction is discounted and the urgent need for hi-tech obstetric equipment is promoted. Whilst rhetorically, the enlargement of units stems from economically rational motives, there is no empirical evidence which demonstrates that this trend is the best or preferred practice. Rather, it has developed from a positivist obstetric approach where the method determines what counts as substance.

The process of economic rationalism sets 'efficiency and effectiveness' over social justice (Pusey 1991). For example, the escalating rates of medical and surgical intervention that lead to costly physical, emotional, and economic outcomes (Johnston and Arnott 2004) are ignored. Moreover, in Crighton, anecdotal evidence points to the potential dangers for service users and their infants owing to low staffing. In Bingham, similar dangers are reported to be due to the insufficient skills of team midwives. In addition, a form of medical hegemony, which promotes a

technologically deterministic approach to childbirth,[21] obstructs the full expression of *Changing Childbirth* thus paying lip service to service user choice and continuity of care.

### *7.5.4 The amalgamation of maternity provision. Economic rationalism or medical hegemony? The inconsistencies.*

In the field of maternity provision, it is a question of whether funds are spent to organise maternity care around midwifery systems by increasing the number of skilled midwives or by putting funds into new technologies and increased medical expertise. The economics of running large, as opposed to small, maternity units is a highly contested political issue largely devoid of a reliable and precise comparative cost benefit analysis. A number of indications suggest that the amalgamation of maternity services is driven by considerations that are alien to issues of quality such as choice and continuity for the service user.

One significant statistic is that up to 71% of service users in Bingham did not need to see a member of the medical staff while in labour in 1999. This factor alone casts doubts on the need to merge units into large and costly high-tech centres to cater for just below 30%[22] of service users.

So why not close down large units and increase the number of small ones instead? According to Jewell et al. (1992), health authorities find it easier to justify closing small units rather than large ones. Whilst the strength of community units is that they offer a preferred alternative, they are still vulnerable. In their attempt to make a case for community-based units, the authors maintain that savings are easily shown on a balance sheet when community units have to be closed and mothers directed to the district general hospital. However, they point out that what is not easily shown is the increased traveling costs to the health authority and to the family. Even within health

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[21] For example, by insisting that large medicalised maternity units are required for trainees

[22] This figure is likely to vary from unit to unit. Crucially it is likely to be influenced by the ethos of the maternity unit in question. In large centralised teaching units, most service users are likely to be seen, at one stage or another, by medical staff.

districts, services used for maternity care may fall under several budget headings. For example, costs of hospital administration, laboratory, pharmacy and medical salaries are not usually the responsibility of the midwifery manager. A straightforward cost comparison between hospital and community based units is impracticable.

There seems to be no agreement amongst health economists as to the relative costs by place of birth. According to Gray et al. (1981) closing community units saves, if any money at all, only relative small amounts of a health authority's budget, and only in the short term. Jewell at al (1992) contend that if savings are to be sought in the maternity sector, this is more readily achieved by looking at the specialist rather than general practitioner units.

The authors were echoing Mugford (1988:12), who found that,

> "the continuing programme of centralisation of maternity units is not based on good evidence about cost effectiveness and the cost effectiveness of consultant obstetric care has yet to be studied in any detail. One reason for this is the difficulty in obtaining suitable NHS accounting data."

Whether or not the centralisation of maternity services is meant to serve the dictates of economic rationalism, the validity of accounting calculations is dubious especially when estimates are based on partial evaluations of cost effectiveness. A complete cost benefit analysis would seek to calculate the knock-on effects of both medicalised and non-medicalised care. Costings are likely to be arrived at in isolation from the secondary and incidental effects. Glazener (1995) and MacArthur et al. (1991) point out that the true *value* of a non-medicalised service is put aside because such official accounting procedures hide the entire follow-up cost of medicalised maternity service where morbidity after birth is high. Abundant evidence which stresses the benefits of non-medicalised childbirth (not to mention many women's wishes) is dismissed. The attachment, in official documentation, to explanatory accounting models that rely on limited deductive reasoning obstructs the view of a wider window from which to examine the issues more fully.

The link between cost and centralisation is not clear. Moreover, control by the medical profession over its knowledge base is an equally important consideration. As professions grew, they became "explicitly market organisations attempting the intellectual and organisational domination of areas of social concern" (Larson (1977: 5-6). Indeed, Larson goes on to suggest, "the social structure and cultural claims of professions are more important than the work professions do" (ibid 1977:17). This claim is very appropriate in the maternity care field where the drive towards centralisation suggests that, in childbirth, obstetrics is of more consequence than midwifery.

Is the rationale behind centralisation, therefore, a will-o-the wisp decision concocted to bolster given sets of power relations? Abbott (1998), quoting Johnson (1967) and Freidson (1986) might agree.

> "Johnson argued that the professions did not serve disembodied social needs but rather imposed both definitions of need and manner of service on atomized consumers. Writing on American medicine, Eliot Freidson argued that dominance and autonomy, not collegiality and trust, were the hallmarks of true professionalism." (Abbott 1998:5)

Obstetricians have defined what the *problem* is – all births are susceptible to obstetric assistance – and its *solution* – centralised services in obstetrically equipped maternity units. Such a shift secures their occupational imperialism (Larkin 1983).

Examining the impact of NPM on the medical profession, Ferlie et al. (1996) explain that state intervention has not de-professionalized doctors but has simply resulted in professional adaptation. For example, during periods of organisational and structural change, the medical profession is more likely to assert their control, status, and boundaries at both individual and collective levels. Whilst social health policy prescriptions seem to have to bend to the calculative pulse of economic rationalism, according to Degeling, et al. (2001a), the medical profession are more likely to resist or oppose NPM reforms. Certainly, according to Harrison et al. (1992) increased managerialism has not led to a loss of power, influence and autonomy for all the professions because "the forms of the market are not uniform and the impact on different professions is highly variable" (ibid 1992:190). The centralisation of

maternity services clearly ensures that the authority and independence of the medical profession overrides the influence and autonomy of traditional midwifery[23].

### *7.6 Conclusions and Summary*

The study of the two[24]sites indicates that the merging of maternity units discourages the implementation of *Changing Childbirth*. Some of the identified outcomes are that larger units have heightened obstetric activity and have higher user to midwife ratios. Low staffing levels in maternity units are often directly related to unit closures and consequent mergers. Both my study and information from the NCT website (2002)[25] indicate that midwife shortages lead to service users being left unattended during labour and neglected on postnatal wards.

Centralised services also mean that a high proportion of cash and staff resources are likely to go towards obstetric provision away from 'process' needs such as high quality ante and postnatal care, which clinical studies (Campbell and Macfarlane (1966), Tew (1990) and Barkley and Barkley 1998) claim can actually *reduce* the need for obstetric services. Large units, which are usually training hospitals, tend to give undue attention to the high tech aspects of care, therefore encouraging trainees to view childbirth from a pathological perspective (Lawrence Beech 2000). Whilst EC/NPM is an important factor compelling the centralisation of services, this conclusion cannot be separated from a critique of the technologicisation of birth and the questioning of policies which seek new technologies for their own sake instead of harnessing and adapting them to human needs.

The NPM efficiency package means more stress and a higher workload for practitioners as well as fewer beds and shorter inpatient stays for the service users.

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[23] See Appendix 5: The Development of Maternity Care

[24] Effectively, the comparison is between Crighton's main labour ward and its small NDU and between Bingham and Crighton. Responses from participants from a third site, Warnick, are also included.

[25] Maternity services degraded by 'stealth' says NCT'
http://www1.nctpregnancyandbabycare/nct-online/stealth.htm

Ultimately, centralisation removes choice not only through the closing down of local maternity units but also because large units create an ambience wherein service users are streamlined. Their needs and choices are heavily adapted to the needs of the organisation. Centralisation is also likely to create fragmented services and discontinuity for the service user. For example, participants fear that the effectiveness of team midwifery in Bingham is threatened when it merges with Warnick. Moreover, in a large unit, the chances of receiving conflicting advice and encountering unfamiliar faces increases.

The centralisation strategy reverses the recommendations of the key 1993[26] reports, *Maternity Services in Scotland* and its English equivalent, *Changing Childbirth.* Research (Flint et al. 1989; Rowley, 1993; and Kenny et al.1994) has consistently established that quality care and support in small or medium units, optimises the birth experience and that, for the vast majority, childbirth does not require high-tech expensive obstetric care. Yet, evidence supporting low tech maternity care has been put aside in favour of a new public management strategy that distances both service users and most health care practitioners from central decision-making. Findings suggest that such a strategy augments clinical stress owing to, inter alia, imposed economic constraints that result in the lowering of staffing levels.

In conclusion, high tech births are not progressive in the sense that they are an improvement on natural methods. Increased technologicalisation can be viewed as separate and distinct methods of assisting childbirth. The dismantling of small and successful maternity care units has increased the gap between social health policies, such as *Changing Childbirth,* and practice as service user choice and continuity of care are likely to decline when units merge. Apart from the dictates of ER/NPM bringing about the re-structuring of maternity care services, the expansion and development of obstetric expertise is also key to the management and direction of current maternity care provision in Scotland and beyond.

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[26] Provision of Maternity Services in Scotland – A Policy Review (1993) SHHD

This chapter examined the impact of managerialism on maternity care and the centralisation of these services as one of its key consequences. The next chapter examines how this strategy is intertwined with financial directions and the power of the medical profession.

# Chapter eight

## Fiscal organisation and professional cultures: a comparison of the two sites

### *8.1 Introduction*

Apart from fiscal reorganisation, radical changes in the public sector during the last three decades have included other developments such as the sovereignty of the customer and the casting aside of traditional public sector and professional values. This chapter examines the fiscal organization and clinical approaches of the large and medium-sized unit and discusses some of their outcomes in terms of service user choice and continuity of care. Following an overview of the clinical activity and physical resources in each unit, this chapter includes a comparative analysis of budgeting and finance and the way in which each unit responds to the impact of ER/NPM; it examines the impact of some aspects of the NPM revolution on the distinct professional values of midwives and obstetricians; briefly examines the interrelationship between professional cultures and technological determinism and examines the implementation of continuity of care and service user choice as recommended by *Changing Childbirth* (1993) and as implied by the NPM logic of customer sovereignty.

This chapter compares two maternity units[1] distinguished by size, organisational structure and locality. Bingham, a medium-sized maternity unit is compared to Crighton, a hyperunit, which is also a training hospital. Apart from the vast

[1] References to a third unit, Warnick, are included if and when relevant.

differences in their physical and human resources, they adopt distinct midwifery systems and budgeting strategies.

### *8.2 Clinical activity in each Unit*

The initial impression one gains from being inside these two units, as well as from interacting with their health care professionals, is strikingly dissimilar. This contrasting impression continued throughout fieldwork. Apart from the different methods of gaining access to each unit and the diverse ways the participants were chosen[2], both the ambience of the units and the general attitude of the health care professionals differed in many ways. Supervision of clinical activity in Bingham appeared to be relatively well co-ordinated whereas Crighton's management appeared dispersed and less directed. The atmosphere in Bingham was generally relaxed but poised for action – whereas Crighton seemed to oscillate continuously between periods of rest and periods of hectic activity.

[2] See Chapter 4 *Design and Methodology of the Enquiry*

*8.2.1 Physical resources*

Each unit is equipped with: antenatal; intrapartum (with obstetric theatres); epidural services; access to High Dependency Unit and postnatal and neonatal services. Table 8.1 sketches out a comparison of physical resources.

**Table 8.1 Physical Resources**

| | Crighton R.I. | Bingham R.I. |
|---|---|---|
| Approx. number of births p.a. | 6,418 | 1,492 |
| Labour ward rooms | - | 6 |
| Labour ward beds | 14 | - |
| Ante/post natal beds | 90 | 28 |
| High dependency beds | 4 | 3 |
| Normal delivery beds | 4* | - |
| Theatres | 2 | 1 |
| Cots | 40 | 12 |

**Including one birthing pool room*

*Adapted from MSPG 2000[3] and Maternity Clinical Task Group 1999[4]*

Bingham has no poolroom for water births nor does it have a ward set apart for 'normal deliveries' because normal deliveries can take place within any of the six labour rooms. Although both units are categorised as consultant units by ISD (Information and Statistical Division), Crighton, being a teaching hospital, is more 'medicalised' than Bingham. In Bingham, there is no equivalent to Crighton's two separate and contrasting divisions: a main obstetric ward and NDU (Normal Delivery

[3] *Final Report of Maternity Services Project Group January 2000* 'Bellham' Acute Hospitals NHS Trust. In order to maintain anonymity, the full name of the report is excluded from the list of references.

[4] *Maternity. Achieving Change in Partnership* Clinical Task Groups August 1999 NHS in 'Crighton.' In order to maintain anonymity, the full name of the report is excluded from the bibliography.

Unit). Service users in Bingham, with its six labour wardrooms, are more likely to experience a total midwife-led delivery rather than a medically assisted one.

### *8.3 A comparative analysis of budgeting and finance[5] in the two units*

This section looks at oral and statistical evidence as well as evidence from other studies which evince the impact of different midwifery systems on some of the cost of provision. An analysis of the experience of distinct budget holding in the two sites is linked to some direct cost comparisons published by the Information and Statistical Division (ISD) Scotland. Comparative perceptions of efficiency savings and efforts to cut costs and eliminate waste are also examined.

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[5] See Appendix 4 for 'technical aspects of finance and budgeting',

*8.3.1 Funding maternity care*

Findings show that the smaller maternity unit is in a better position to organise and take control over its finances whereas the larger unit with its funding hierarchy is disempowering for the budget holders. In Crighton, clinical managers hold a 'dummy' budget as by the time funds cascade to their level, the cash levels are so stretched, there is no further room for manoeuvring expenditure. See figure 7.1 for a comparison between the two budgeting structures in Crighton and Bingham.

**Fig. 8.1 Budgeting structures – a comparison**

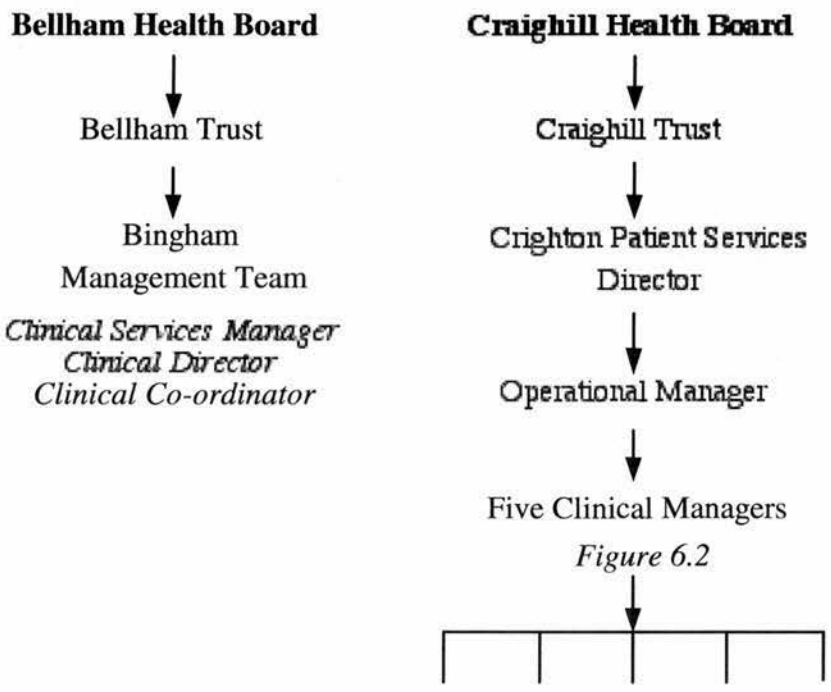


*Figure 6.2*

In Bingham, funds from the Health Board flow down to the Trust and finally to the management team. In Craighill, funds flow down from the Health Board to the Trust reaching the Patient Services Director who apportions a budget to the Operational

Manager who in turn oversees five clinical directors who are responsible for five distinct areas[6] of maternity care.

Bingham's budget holding management team claim to be able to satisfy funding limits whilst maximizing choice and continuity for the service user, describing their system as "effectively, a better deal for the same amount of money." The team midwifery system in place, assured the Clinical Services Manager, results in cost savings because the pay structure and working conditions have been re-designed to (i) eliminate the costly employment of high graded staff at week-ends (ii) eliminate special duty payments (iii) give midwives a flat rate salary incorporating public holidays, night shifts and back shifts and (iv) incorporate 13% sickness absence within their team to cover short term sickness so that cover may be sorted amongst the individual team members. In addition, because retiring higher-grade staff were not replaced, it was possible to increase the number of low-grade practice midwives at no extra cost. Not only has the unit in Bingham eliminated a number of high grade staff, it has also changed the grading and pay structure away from national practice [7] thus maximising cost efficiencies on staff deployment. In contrast to Bingham's unique system, Crighton retained the customary fragmented midwifery system and national pay structure and split nominal budgets amongst six clinical managers. Like Bingham, Crighton attempts to save costs by not replacing high-grade staff immediately. For example, in Bingham, each of four nursing officers was replaced with "one and a half to two practicing midwives."

The downside is that this level of rationality sets 'efficiency and effectiveness' over the need to employ sufficiently skilled staff. One key feature of the influence of economic rationalism in Bingham is the way managers accept and staff are expected to accept conditions imposed by a cascading management regime. This position leads to a tolerance of new and less generous working conditions on the pretext of

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[6] See figure 5.2 in chapter five

[7] But according to the Trust's Management Accountant for this Directorate, the merger with Warnick R.I. means that Bingham R.I. midwives will soon be expected to revert back to national pay structures and conditions.

improved quality such as increased service user choice and a higher degree of continuity of care. Thus, the new public management code legitimises the uncoupling of the economic needs of the health practitioner and health needs of the service user.

*8.3.2 What budget holding entails*

Although the managerialist regime has led to the tendency to appoint senior managers with 'general' management skills rather than professional expertise, the budget holders interviewed in the two maternity units were all health care practitioners. The expectation that such public sector managers should adopt private sector management models incorporating private sector values (Stewart and Walsh 1992) was generally felt to be a strain by the budget holders interviewed.

Budget holders in both the Crighton and Bingham units perceive the rigours of annual limits on budget levels, ultimately, as a handicap that obstructs the smooth availability of resource requirements. Both sites reported that funds may not be available at the start of the financial year when they are needed most as budget holders are urged to exercise caution and prudence in their spending. Since keeping back monies for use beyond the financial year is not permitted, these budgetary restrictions often lead to a surge in expenditure towards the end of the financial year, at a time when spending may not be urgently required. Participants from both units agreed that the system comprises an excessive amount of red tape – a factor which reduces *overall* efficiency.

The Health Board covering Crighton Maternity Hospital includes one other maternity unit, so that about one in twenty women living in the Crighton area deliver their infants in a maternity unit which is about fifteen miles away from Crighton's catchment area. In addition, owing to Crighton's availability of advanced technological treatments for high-risk pregnancies and births, about a quarter of infants born in Crighton are delivered by service users who come from other Health Board areas across Scotland. Similarly, within the Health Board that covers Bingham and Warnick, GPs are liable to book the service user in either of the two units. Table

8.2 gives a comparison of health board costs of maternity services commissioned in 1999/00.

**Table 8.2 Maternity Services commissioned (purchased) 1999/00**

| **Health Boards** | Population | Comm. Midwifery Cost per visit | Tot. exp. £000 | TMS |
|---|---|---|---|---|
| Covering Crighton | 778,500 | 108 | 22,316 | 29 |
| Covering Bingham & Warnick | 277,600 | 158 | 9,653 | 35 |
| **Total** 15 Scottish Health Boards | -- | -- | 168,393 | -- |
| **Average** | -- | 31 | -- | 33 |

*TMS —>Total maternity services expenditure per head of population*
*Comm Midwifery --> Community midwifery*
*Adapted from ISD National Statistics*

The Heath Board information in Table 8.2 shows council area population figures and these may not be properly aligned to designated hospital catchment areas. The figure showing the running costs in Table 8.3 are gathered from a variety of sources but they all relate to the year 2000. The budget figures in the right hand column were gathered during fieldwork from the key budget holders in each unit whilst the population figures come from the General Register Office indicating council area population figures.

**Table 8.3 Running costs serving maternity unit populations**

| Maternity Unit | Maternity Budget | Population served | Budget per head of population |
|---|---|---|---|
| – | | | |
| Crighton | £16m | 626,910[8] | £25.52 |
| Bingham | £4.5m | 144, 320 | £31.18 |

*GRO statistics, Scotland - June 2000 and Fieldwork 2000*

Whilst budget levels in Bingham are reported to be stretched, there were no serious complaints about the amount and the two key budget holders revealed that they are free to manage it as they think fit. This approach contrasts strongly with that at Crighton where six budget holders were interviewed and where all intimated various degrees of disempowerment. Apart from the neonatal ward clinical manager, who is able to raise some revenue from student placements and conferences, the remaining budget holders interviewed complained that budget-holding meant having a good deal of responsibility without the licence to take risks: their role left no room for creativity, innovation, and entrepreneurship. This lack of autonomy is further exacerbated by the lack of intelligible or lay-person-friendly monthly statements and the restrictions that accompany a very hierarchical and over-bureaucratised system of

[8] Based on General Register Office June 2000 statistics -Scotland

financial management. For example, during her interview, the operational manager disclosed that it is the Divisional Finance Team[9] who decides whether anything over £200 ought to be spent. She described the financial system as dated, ineffective and out of touch with real needs.

The Clinical Director in Bingham explained that, in some respects, a rolling programme was in operation whereas the Operational Manager in Crighton explained how much a rolling programme was needed because the present system is excessively driven by financial targets. She protested that budget holding is not about the purchase of maternity care but about squeezing provision from a severely constrained budget.

For the six budget holders in the larger unit, budget holding is seen, particularly by the five clinical managers, as a passive role whereas in the smaller unit, the two principle budget holders displayed more self assurance and satisfaction with their role. Furthermore, Crighton budget holders were not in agreement about where cost savings or increments ought to be made[10]. Such wide disagreements are very unlikely in Bingham where the clinical director, who is the key budget holder, makes joint financial decisions with the clinical services manager.

### *8.3.3 Cost of Inpatient, Outpatient and Day cases*

Bingham's budget holders apply firm expenditure controls with a drive towards drastic cuts in inpatient stays. As Table 8.4 indicates, the average length of inpatient days in Bingham is lower than those in Crighton. Whilst financial considerations are increasingly determining how inpatient stays are managed and curtailed, the service user's desire to shorten her stay could be linked, inter alia, to dissatisfaction and high levels of stress (such as noise and lack of privacy) in the hospital environment. These considerations, however, remain outside the scope of this study.

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[9] The Divisional Finance Team are non-clinical personnel residing outside the maternity care unit See Fig. 6.1 Chapter six

[10] See Tables 6.4 and 6.5 in Chapter 6

The gross cost per outpatient attendance is about 33% higher in the smaller unit. Similarly, the gross cost per inpatient case is also about 7% higher. Conversely, the gross cost per day case is about 10% higher in the larger unit. Inpatient and day case costs in both units are lower than the Scottish average. Although no clear picture emerges, if Warnick's figures are taken into account, the general indication is that the centralisation of services is likely to result in economies of scale.

**Table 8.4 Cost of Inpatient, Outpatient and Day Cases in three units 1999/00**

| | Inpatients | | | Outpatients[11] | | Day cases | |
|---|---|---|---|---|---|---|---|
| | Dis | ALS | GCC [12]£ | TA | GCA £ | Cases | GCC £ |
| **Crighton** | 8,788 | 2.4 | 1,075 | 18,294 | 79 | 5,351 | 202 |
| **Bingham** | 2,556 | 2.2 | 1,101 | 7,423 | 117 | 1,453 | 182 |
| **Warnick** | 2,271 | 3.5 | 1,549 | 10,048 | 72 | 590 | 215 |
| **Scot.Avge** | | 2.7 | 1,122 | | 65 | | 219 |

*Dis=>Discharges: GCA=>Gross cost per attendance: TA=>Total attendances*
*GCC=>Gross cost per case: ALS=>Average length of stay*

*Adapted from ISD National Statistics*

Comparability amongst Trust costs is very difficult because what may be demonstrably cost-effective in one Trust may not be so in another. According to Carson and Waugh (1999) different Trusts employ different methodologies of costing, the age of their equipment varies, as do their clinical techniques. Therefore, costs attributed to different trusts and which can be drawn from the Scottish Health Service Costs book published by the Information and Statistics Division need to be studied with caution. For example, Bourn and Ezzamel (1986:55) maintain,

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[11] Consultant Outpatient Attendances cover all attendances made at professional and technical departments by patients from outwith the hospital who are not attending as part of day patient or day case care.

[12] Gross costs include (i) *direct costs* such as medical, midwifery, pharmacy. PAM, Theatre, Laboratories and supplies as well as (ii) *allocated costs* such as administration, teaching, catering,. See Glossary for full listing.

> "The reduction in the average cost per patient-case is very likely to be matched by a rise in the other main costing statistic, the average cost per patient-day. This is because the day(s) saved will probably be relatively 'cheap' days of recovery in a ward; the 'expensive' days of tests, diagnosis and active treatment continue"

Williams' (1985) study also shows how reducing the length of stay reduces average cost per case and also increases average cost per patient-day, but may also lead to a lower bed occupancy rate, a higher average cost per available bed-day, and apparently excessive usage of theatres, drugs, and dressings relative to budget. Overall, accurate costing of maternity care is a relatively complicated process involving outpatient care, community care, hospital admissions, and primary care. Costing can sometimes encompass two types of Trust, and several directorates within those Trusts as well as General Practice.

### *8.3.4 Economic rationalism: coping with the cost efficiency culture*

Compared to Bingham, staff at Crighton are encouraged to be more cost conscious and to look into reasons why expenditure may be seriously fluctuating from month to month. This unit sends its staff on *Finance Awareness Days* that consist of seminars on NHS finance policy and practice and are devised to instill cost awareness and responsibility. In both Crighton and Bingham, midwifery staff are encouraged to initiate cost cutting actions in consultation with medical staff. This cost consciousness culture can alter the volume of routine matters, for example, reducing the number of unnecessary specimens that are sent to the laboratory. However, the numerous other cost cutting measures mentioned[13] save relatively small amounts compared to the savings gained by reducing the number of staff or replacing skilled with less skilled staff.

Ideas and suggestions about the way in which overall finance could be managed differed depending on the clinical perspective. One midwife in the NDU at Crighton claims that low-tech births can save money whilst a consultant obstetrician in the

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[13] See chapters five and six

main labour ward sees the investment in advanced technology, which can detect problems early, as saving costs in the long term. Although these views are not necessarily mutually exclusive, they do stem from a fundamental polarity that does exist in relation to best birthing practices.

Participants from the two units differed in their perception of the need or otherwise of duplicated roles - in particular those of GPs and midwives. Bingham's clinical director thinks that the roles of midwife and GP are complementary because the GP has an overview of the patient that the midwife does not hold. Contrasting with this approach was the view expressed by the operational manager in Crighton who believes that GPs and midwives ought to work together but that GPs ought not to duplicate the routine care which midwives carry out, adding that it is also wasteful when both midwives and consultants look after low risk women. The difference in their approach may be due to a number of factors: clinical experience, disciplinary perspectives and, not least, the dissimilar midwifery systems and organisational structures within the two units. The participant at Crighton perceives duplication as an alarming cause of concern costing "a phenomenal amount of money," whilst the participant at Bingham accepts that there is "always some duplication of roles but it is not necessarily a bad thing."

A 1998 survey (Audit Commission) noted that resources were wasted due to an overlap of roles between medical and midwifery staff in both hospitals and health service centres. The same survey revealed that (i) midwives' job satisfaction was low (ii) shortage of funds put midwives under pressure to rush deliveries and get service users in and out of hospital as quickly as possible and (iii) tensions and conflicts between staff led to staff arguing with senior staff in front of patients. Whilst the study did not set out to measure midwives' job satisfaction, there were admissions, from the larger unit, that midwives are under pressure owing to bed shortages. The study suggests that any tensions and conflict relating to the different approaches to the birthing strategies are exacerbated by the consistent lack of funds

### *8.3.5 Economic rationalism: costing community midwifery, CAM and high tech births*

During fieldwork, Crighton was getting ready to change over to a total community midwifery system. Such a system replaces ante and post-natal hospital visits of low risk women with home visits by the community midwife. Provided the system allows an adequate number of highly skilled midwives, it increases the chances of the provision of one-to-one continuity of midwifery care.

Crighton's operational manager maintains that community midwifery offers a cost-cutting solution because (i) such a system is expected to reduce hospital-running costs and (ii) midwife led care is more cost effective in the medium and long term. A consultant from the same unit, however, believes that community midwifery is more costly than it is believed to be especially if it means, "equipping lots of different centres." He was referring, here, to the proposed setting up of satellite maternity clinics outwith the hospital. Another consultant also pointed out how midwives' travelling time and cost of travel would reduce cost efficiency overall. He explained that when women come to the hospital, ten of them can be tended to by two members of staff within a couple of hours or less whereas two community midwives could spend as much as two hours travelling to and from the service users' homes.

Training midwives for community practice would require a substantial injection of funds. Compared to Bingham, Crighton gives greater importance to the requirement of highly skilled community midwifives. In Bingham, it is supposed that the appropriate skill mix within teams is adequate for community midwifery, whereas Crighton plans to have comprehensively trained community midwives. It is supposed that effective midwife-led care in the community is likely to result in a lower caesarean rate and other instrumental births, thereby reducing medical costs.

Bingham's integrated (community and hospital) midwifery system has been successfully created within their allocated budget with changes in team midwives' pay structure and working conditions partly accounting for this qualified success. Table 8.2 shows that health board costs covering Bingham are higher per head of

population than those of the health board covering Crighton and, in particular, the cost per community midwifery visit (as opposed to integrated team midwifery[14]) is substantially higher in areas covering Bingham and Warnick than in Crighton. The difference in cost may be due to various factors. In particular, Bingham and Warnick cover a number of widespread rural areas in their catchment areas. Given the caveat by Carson and Waugh (1999) in section 8.3.3, these statistics do not represent the larger picture and cannot be regarded as conclusive. The management team at Bingham asserted that their team midwifery system has improved quality - in particular improved service choice and continuity of care - without costing more. Nevertheless, participants from neighbouring Warnick questioned the expertise of Bingham's integrated midwives, doubting whether it is possible for midwives to display expertise in all areas and stages of midwifery care. One participant also pointed out that some midwives might not be satisfied with the pay structure and working conditions.

The likely cost of including (or substituting) Complementary and Alternative Medicine (CAM) in maternity units is another issue that resulted in mixed reactions. One community midwife leader, a practising reflexologist in Crighton, claimed that CAM could cut down on overall costs, whereas Bingham's Clinical Director took the opposite view pointing out that extra funds would be required to train staff who are already working within tight time constraints. Rather than reflecting a difference in approach to CAM in the two sites, this divided view stems from their distinct professional perspectives. In both sites, the medical profession have a grip on institutional control, defined by Dent (1991:69) as "control of the health services labour processes of diagnosis, treatment and care of patients" and, as such, CAM, which is largely though not exclusively, promoted by midwives, is relegated less importance.

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[14] Community midwives work solely in the community, whereas integrated midwives work in the community as well as the hospital.

### *8.4 Professional cultures, social health policies and NPM*

The previous chapter examined the centralization of maternity services – and concluded that ER/NPM is a major factor responsible for the merging of maternity care units. This section looks at the extent to which other influences, such as divided professional perspectives and technological determinism, are significant in determining the organisation, structure and delivery of maternity services and hence the implementation of social health policies. Findings demonstrate how smaller maternity units, which are usually low tech, are predisposed towards midwifery care and birthing strategies which allow the implementation of the principles of *Changing Childbirth* (1993).

#### *8.4.1 Small units and large units: midwifery versus obstetric care*

Small units are more likely to be women-centred with a lower birth to midwife ratio allowing the possibility for women to receive continuous supportive care. Supportive care has been described as constant presence, reassurance, confident assessment, encouragement, and comforting touch (Reproductive Care Program of Nova Scotia 2000). These midwifery activities are associated with a decrease in the length of labour, the lack of need for analgesia and the low incidence of operative birth (ibid 2000).

A comparison between the two units (Table 8.5) shows that Crighton's birth-staff ratios are higher than those of Bingham where Bingham is a medium unit delivering around 1,492 births and Crighton's about 6,418 per year. Although Bingham retains a proportionally higher level of consultants than Crighton, it has lower levels of medical staff overall.

**Table 8.5 Birth –staff[15] ratio[16] comparisons[17]**
**1999 Annual figures**

| | Crighton | Bingham[18] | Scottish Average |
|---|---|---|---|
| Live Births to Midwives | 29: 1 | 25: 1 | 23: 1 |
| Live Births to Consultants | 513: 1 | 373: 1 | 401: 1 |
| Live Births to medical staff | 100: 1 | 373: 1 | N/A |
| Midwives to Consultants | 13: 1 | 15: 1 | 17: 1 |

*Adapted from ISD National Statistics*

In a larger unit, particularly if it has a high proportion of trainees, the importance of supportive care is often overridden especially when there is an insufficient level of midwives. My observations of maternity care at Crighton has led me to conclude that low staffing is a serious problem and, as one participant pointed out, at times verging on being dangerously low. Crighton is the product of several merged units and owing to the rationing decisions at the time of these mergers, the hospital did not take on the full quota of maternity care practitioners from the closed smaller units.

> "What's happened is they shut these units and brought them all to the one site but not brought the staff with them. They've tried to over-rationalise" (Senior midwife).

According to my findings, the outcome of these mergers has been disadvantageous in a number of ways. *Firstly,* midwives coming in from smaller units were used to a different midwifery culture: one, which was less stressed, less medicalised and more woman-centred so that new midwives needed a fairly lengthy period of adjustment. *Secondly,* both incoming and existing midwives were expected to take care of a higher number of births than was the case before the merger. *Thirdly,* merging units usually means reorganising management with its attendant disruptive consequences.

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[15] Figures for midwives represent headcounts.

[16] Figures are rounded to the nearest integer.

[17] Figures for consultants represents whole time equivalent (WTE) as opposed to headcount.

[18] Bingham has four consultants with no junior medical staff located in the maternity wing of the hospital

The closing down of small units has been perceived by various organisations, such as AIMS[19] and NCT[20], as a high-handed method of removing choice because smaller units are not susceptible to higher morbidity and mortality rates. Indeed the Cumberledge Report (1993) and the Winterton Report (1992) both suggest that small units should no longer be closed down on grounds of cost. Moreover, small units, such as Birth Centres[21], are said to offer high quality postnatal care, an aspect of care that women most appreciate (Audit Commission 1998). The same report lists the shortcomings of postnatal care provided in hospitals: low staff-to-woman ratios, a noisy environment, insufficient help with breastfeeding, difficult visiting times for families and unhygienic facilities.

In an era of evidence-based medicine, the grand irony is that existing evidence is ignored. For example, evidence shows that small units are safe, less costly and beneficial in many ways because they are more likely to have a relaxed atmosphere and where midwives give women emotional support and attention throughout their labour (Oakley et al. 1996, Oakley 1989, Flint 1991, Hodnett 2001). This is especially the case in units that offer a midwifery philosophy of care and support for women who are considered to be 'low risk', and where there is minimal or no intervention. Such units usually offer a 'home-like' environment and are often sited adjacent to the facilities of the obstetric unit or in separate surroundings out with the major unit. At the same time, there is no evidence either in this study or in other known studies that suggests that large units are more beneficial to women and their infants; or that they are the safest and most natural places to give birth.[22] Midwives working in the small NDU at Crighton asserted that all normal deliveries can safely take place in the service user's own home and that the more private and the fewer the

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[19] AIMS Association for improvements in the maternity services

[20] NCT National Childbirth Trust

[21] Definition of Birth Centre: A home-like facility, existing within a healthcare system with a programme of care in the wellness model of pregnancy and birth. These centres are guided by the principles of prevention, sensitivity, safety (appropriate medical intervention), and cost effectiveness. These units provide family centred acre for health women before, during and after normal pregnancy, labour and birth (National Association of Childbearing Centres, 1995) http://www.birthcenters.org

[22] However, there is widespread agreement that an optimally equipped obstetric hospital could save the life of the minority of high risk pregnant woman and her offspring.

number of health practitioners involved, the more optimal is the event. In contrast, a labouring woman in the main obstetric ward at Crighton is likely to be approached by a variety of midwives and medical staff or worse still, during times of clinical stress owing to staff shortages, she may be left totally unattended.

Most consultants would agree that a caesarean section is not the safest and healthiest option following a normal pregnancy. Table 8.6 shows how the two medium sized units (Warnick and Bingham) have lower caesarean and forceps rates than Crighton which is a hyperunit. The epidural rate is not shown but a forceps delivery often follows the administration of an epidural. The significant differences between Bingham and Warnick in their caesarean, forceps and spontaneous rates is likely to be due to their distinct midwifery system. Unlike Bingham's integrated system, Warnick's midwives specialise in either ante, post, or intrapartum care. Nevertheless, all three units are consultant units and service users are, therefore, likely to be exposed to interventionist approaches.

**Table 8.6 Live births – mode of delivery in three units :**

**Year ending 31 March 2000 (percentages)**

| | Crighton | Bingham | Warnick[23] |
|---|---|---|---|
| No of live births[24] | 6,418 | 1,492 | 1,618 |
| Spontaneous | 64.2 | 73.3 | 65.8 |
| Forceps | 9.1 | 4.5 | 6.5 |
| V.E.[25] | 3.6 | 6.2 | 6.1 |
| Breech | 0.8 | 0.8 | 0.6 |
| Elective Caesarean | 16.0 | 11.0 | 15.2 |
| Emergency Caesarean | 6.3 | 4.3 | 5.9 |
| **Total Caesarean** | **22.3** | **15.3** | **21.1** |
| Percentage induced | 23.4[26] | 23.5 | 42.3 |

*Adapted from ISD National Statistics*

Whilst medium sized consultant units are becoming more medicalised over the years, the larger the unit, the more interventionist the approach is likely to be. In Crighton's main labour ward, most women receive obstetrician-led, medicalised care, with midwives acting largely as 'obstetric nurses'. In medically oriented units, such as those within an acute Trust, women are generally viewed as 'patients' needing care within the safety of the hospital system. Protocols of care, which are mainly consultant-led, often promote a pathway of medical intervention whether the woman is considered low or high risk. This state of affairs contrasts sharply with other units where the midwife is acknowledged as the expert in normal childbirth and takes responsibility for clinical decision-making.

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[23] Warnick serves a small city population and combines hospital and community services.

[24] ISD statistics showing stillbirth rate relate to local council area rather than individual maternity units. In 2000, the stillbirth rate in the Crighton area was 4.4, whereas in the Bingham area it was 3.2 and in the Warnick area it was 3.5. These figures are not attributed to the maternity units.

[25] Vacuum Extraction

[26] Findings show that practitioners have different perceptions of when induction does take place.

Although the service user's home is the optimal location for a normal birth, few consultants would favour or encourage a large increase in home births. Obstetricians interviewed were decidedly more outcome focused than midwives and concerned largely with ensuring a live birth. Midwives, on the other hand, tend to be more process oriented focusing on service user needs throughout her pregnancy and beyond. In-depth interviews revealed that continuity and *supportive care* throughout pregnancy, and crucially during the intrapartum episode, is a concept that is outside the perceived obstetric role. By and large, the orthodox obstetric role ignores the qualitative experiences of mothers and their infants.

How childbirth is defined and who defines it can have a significant impact on the way it is resourced and managed. For example, the decision to centralise maternity services is based on a wholly obstetric perspective of maternity care. The contrasting view is that small units, and especially Birth Centres, offer increased consumer satisfaction (Ernst 1986; Rooks et al. 1989; Spitzer 1995; Campbell, R 1997; Gillis1995; Hayes 1996 and Saunders et al. 2000). The likelihood of toxicity resulting from medical interventions is widely accepted as a possibility by midwives and obstetricians interviewed. However, it is difficult to set up studies that provide exclusive proof that such interventions induce a cycle of ill health.

This study found that compared to the smaller unit, the large unit is not likely to promote optimal intrapartum episodes whilst the smaller unit is more likely to provide care and support throughout pregnancy and childbirth. Although the midwifery system in place needs to be taken into account, stress and intervention on the one hand, and continuity and emotional support on the other, are strongly correlated with the size of the unit, at least in this study. Various studies (Oakley 1996, 1989; Flint 1991; Hodnett 2001) evince that support throughout pregnancy, during childbirth and postnatally, is likely to decrease premature infants and infants with a low birth weight. These studies also maintain that care and support throughout pregnancy and childbirth is likely to reduce interventions as well as increase breastfeeding rates.

Yet, one consultant in Bingham was not willing to accept these studies as valid evidence. Effective and successful non-interventionist birthing cultures demonstrate that obstetric birthing methods are not necessarily 'objective' and value free. Nor is the use of advanced technologies always evidence-based. Thus, the philosophical and professional divide is based less on science and more on two distinct belief systems.

### *8.4.2 Evidence-based midwifery*

Recent history of maternity care services is strewn with many 'success stories' up and down the country relating to small midwifery units within hospitals, stand alone midwifery units, DOMINO schemes, home births and a host of other models which eschew obstetric intervention. Apart from evidence of consumer satisfaction referred to in section 8.4.1, the nature of this success constitutes high midwifery job satisfaction (Saunders et al. 2000); women feeling empowered (Spitzer 1995); high normal delivery rates (David et al. 1999; Saunders et al. 2000; Wladenstrom et al 1997; Durand 1992); fewer inductions (Saunders et al. 2000); lower caesarean section rates (Feldman and Hunt 1987; Saunders et al. 2000; Durand 1992; Rosenblatt et al. 1997). Often when a good scheme is set up and subsequently gains a healthy reputation, it gets wiped out usually on the pretext of lack of funds or the much disputed issue of obstetric safety. Nevertheless, Saunders et al. 2000; Reinharz et al. 2000; Spitzer 1995; Rosser 2001; American Public Health Association 2001; Anderson and Anderson 1999; Gabay and Wolfe 1999 and McCourt and Page 1997 point out that it is possible to run low-tech community midwifery schemes and small birthing centres which are more cost effective than large maternity units. Ironically, attempts to 'rationalise' services do not exclude the purchase of high tech equipment and the recruitment of specialists to deploy such new technologies in large obstetric units. In his analysis of economic rationalism Pusey (1991:184) observes how "the system sterilises spontaneous or unwanted micro-cultures that do not fit in with its strategic aims." The absence of studies providing evidence that the increase in medical intervention rates do not result in a loss of health for the family and the community, as well as counter evidence demonstrating the cost effectiveness of large obstetric units indicate, in this case, the irrational basis of economic rationalism.

The maternity unit at Bingham has gained a good reputation for combining an integrated midwifery system which enhances continuity whilst keeping within the imposed budgetary limits. However, four years after its inception, this model is now facing serious organisational disruption as it is expected to double its capacity over the next few years whilst the Warnick unit closes down. Whilst Bingham's overall organisation is not beyond criticism, its management is considerably smoother and much more co-ordinated than the continuous organisational restructuring in Crighton causing clinical stress and a certain amount of confusion. This merger will involve a total rehabilitation of the site in order to enlarge and modernise it. This is another example which shows that the rationale behind the centralisation of maternity units is not manifestly underlined by issues of cost efficiency.

The centralisation of maternity services is not an evidence-based practice. It could be argued that neither the low risk nor the high-risk woman gains from delivering in large units. Low risk women are in danger of receiving unnecessary medicalised care (Klein et al. 1983), whilst high-risk women may be too far away from the unit - or, as can often happen when the normal is perceived as abnormal, skill and time resources are not given to those who need it most. Centralisation is not a popular option for service users. According to a MORI survey (May –June 2000) only 32% of respondents (women aged between 17 and 55 years) opted for full centralisation to take place. The justification to centralise services bears close links to the traditional obstetric-midwifery divide as much as it does to the dictates of economic rationalism.

*8.4.3 Professional cultures and technological determinism*

The provision of maternity care is not entirely about bricks and mortar and the stretching of budgets to available limits. It is also about the birth of new technologies and their impact on the nature of the services being provided.

> "New technologies (and new organisational imperatives) alter not only the way in which the service product is delivered, they alter what the service product is" Coombes and Green 1992:294).

In the last 20 years obstetrics have often been cited as an important example of over-medicalisation with its unnecessary and perhaps dangerous over-use of technical

intervention (Garcia et al., 1990). What makes technology a special issue in maternity care are the widely differing perceptions of the appropriateness of these new techniques. For instance, while the use of electronic monitoring of the fetal heart rate is the subject of strong argument, in another field of medicine such as adult intensive care, the use of such a device is seen by most caregivers and recipients as appropriate and necessary (ibid 1990). Technological innovation can give rise to conceptual change and the imposition of value-judgments on technology may stand in the way of a considered view on the benefits and disadvantages of different forms of care. For example, the tendency in the maternity field to use the word 'intervention' with the sense of 'inappropriate interference' excludes from consideration some older techniques which do involve intervening but which are usually used by midwives, such as inhalational analgesia or the Pinard Stethoscope.

Essentially, however, the differing perspectives of the obstetric and midwifery techniques reflect the shift in the boundary between the obstetrician's concern with the abnormal and the midwife's with the normal (Garcia et al., 1990). Illustrating this essential divide is a consultant's concern regarding surgical interventions on the one hand, and enthusiasm for undiscovered technologies on the other.

> "I would have liked to think there are greater ways of understanding and better ways of monitoring babies in the womb; that more understanding might lead to fewer sections. But there's still this incessant increase in the number of sections being done despite technologies to hopefully, you'd think, would give you a better idea of the well-being of the baby in the womb" (Consultant Obstetrician, Crighton).

The technological changes she would like to see are "not to do with giving birth. It's to do with diagnosing fetal abnormalities in the womb and that kind of thing."

In a changing medical world where new and powerful technologies mingle and compete with tamer alternative therapies, it becomes difficult to draw the line between safe medical science and the politics of treatment. Since only an estimated 15% of medical interventions are supported by solid scientific evidence, there seems to be a certain amount of 'scientific' ignorance about what is and what is not viable (Smith 1991). Moreover, even assuming that there is solid evidence, there remains

the problem of applying it to the specific circumstances of an individual patient (Hunter 1991). The risks attached to interventionist approaches in maternity care are recognised by obstetricians. Indeed one consultant warned,

> "Caesarean section is an operation you can die from. If you do enough caesarean sections, you'll get a death. Patients are not always aware of that, but doctor and midwife must always be aware of it. "

The efficacy of high-tech obstetric care is not always evidence based; yet, the insistence that large medicalised units provide 'medical safety' sends out strong images of the widespread possibility of birth abnormalities. Such projections effectively persuade the public that small low-tech units are no longer safe despite abundant evidence showing the contrary. Furthermore, since the investment in new technologies needs to draw in as many service users as possible, the testing out of new drugs or equipment is done at the expense of an alternative low tech system which is satisfying to the service user as well as being cost effective.

On one side of the professional divide, contenders argue that without medical intervention the infant mortality rate would increase. On the other side, it has been argued that interventions are both excessive and inherently dangerous and that even apparent successes may have long or short-term side effects. It could be argued that the orthodox scientific medical paradigm models the human body on mechanistic assumptions (Samson 1999), removing the patients' control over their body and leading to unnecessary medical intervention. Indeed, such a perspective can be applied across all medical fields.

### *8.5 The implementation of social health policies: service user choice and continuity of care*

Today's models of midwifery care are expected to reflect both the provision of choice and continuity of care. However, there is no single preferred or universally appropriate model for organising midwifery services. Some elements, which are likely to enhance the opportunity for choice and continuity, are an appropriate skill

base for midwives as well as the provision of holistic and integrated care[27]. According to various official documents (SNAP 1994, SPCERH 1999, Maternity Services Advisory Group 1997), all forms of maternity service should minimise the numbers of carers per service user, offer choice, and have a clearly identified leader. In addition, official recommendations always insist on a joint Midwife/Consultant Delivery Unit because of the difficulty in extracting 'low risk' cases. Framework for Action (1993) and the Winterton Report (1992) also insist that women should be cared for by a small number of people within the 'lead carer' concept that emphasises patient choice. However, these documents also insist that where patient choice is a prime focus in the pattern of care provided, 'safety', as defined and understood by obstetricians, ought not to be unknowingly compromised.

### *8.5.1 The influence of the professions on service user choice*

Qualitative data gathered from this in-depth study show that once women are within the hospital walls, choice may be expressed actively – such as when the user comes in with a firm birth plan; choice may also be institutionally framed, for example, when a doctor or midwife discusses the possibility of induction with a service user. Informed choice, which is not institutionally driven, may depend for its execution on available resources such as time and staffing levels. Hospitals are not always in a position to cater for users' options because of the interrelationship between constrained resources, inadequate staffing levels, and issues of safety. This problem applies especially to home births where the appointment of two highly skilled midwives means absence from hospital or community duties that would have to be performed by other time-stretched staff.

The fulfilment of the maternity care ideal constituting maximum choice would require an expansion of maternity wards offering a multiplicity of delivery modes in a very relaxed and highly supportive setting. At present, certain clinical attitudes, the

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[27] Holistic care refers to the ability of an individual midwife to provide ante, intra and postpartum care. Integrated care refers to the provision of care by the same midwife in both hospital and the community.

high-tech hospital environment and limited resources curtail expansion and creativity and, therefore, narrowly circumscribe the expression of individual choice. Moreover, large units are likely to harbour a heterogeneity of obstetric and midwifery philosophies exposing the unit to inter-professional conflict sometimes resulting in inconsistent advice given to service users.

### *8.5.2 Choice and sceptical perceptions of clinical authority*

Owing to the abundance of information that a pregnant woman is able to access, she may feel armed to tackle or question the issue of safety with her health practitioners. As a midwife in Crighton testified, "I think more people will question the doctor than they used to." In both units, choice is understood as an interactive process between the user and the clinician's time, knowledge and leanings. One senior midwife in Crighton, however, put it quite categorically, "responding to choice is not about surrendering expertise." Choices expressed by service users are not always clinically approved.

Midwives informed that although women are expected to complete a birth plan listing their preferences, it often has nothing to do with real choices and final outcomes. The exercise simply adds to the service user's profile. According to midwives from both units, the percentage figure of service users who are able to execute their spoken or written choices could be less than 5% overall.

A 1998 survey[28] conducted in Scotland by the Audit Commission shows that a relatively open choice exists regarding which hospital women choose to deliver in. However, with the increasing number of merged units, women are likely to have no choice but to deliver in the one and only available unit in their area. Once the service user is inside the hospital, choice is expected to be negotiated with members of staff so that they are "involved in the decisions that affect(ed) them" (ibid 1998:53). The survey results showed:

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[28] First class delivery: a national Survey of Women's Views of Maternity Care (1998)

- 8% of respondents did not know they could choose the place of birth
- 65% said they had a choice as to whether or not to go to one hospital in particular
- 92% felt they had a say in whether to have amniocentesis
- 62% had a choice when to go home postnatally
- 39 % had a choice about labour being induced
- 22% had a choice about having an episiotomy
- 13% had a choice whether to have stitches.

Whilst 5% and 11% of respondents said that doctors and midwives respectively "did not take their preferences into account", one in every four of women who were given preferences said that their care did not follow their plan, mostly because their medical circumstances changed (ibid 1998:56).

Usually, official statistics gathered by NHS maternity units exclude choice data. The information gathered is more likely to reflect levels of medical intervention rather than the kinds of service users choices requested and whether they were allowed or denied. Statistics about trends in complementary and alternative therapies are also excluded. Maternity units are not obliged to collate and disclose user-choice data in any form.

This state of affairs encourages the clinicians to dismiss wider options and to focus narrowly instead on medical safety for the mother and the infant. The overriding concern expressed by most, if not all, clinicians is that unless the user makes an informed choice, she is in danger of making an unsafe choice that is likely to clash with the clinicians' ethic. However, once inside a hectic hi-tech environment, it would prove very difficult for the service user not to succumb to what is recommended and available. Therefore, the question is as much on users' unwise and unsafe choices as it is on the practitioners' assurances of what ought and ought not be regarded as clinically safe within the immediate clinical situation and environment.

The impression gathered in Crighton, more so than in Bingham, is that the 'medical safety' issue is often the outcome of the clinical environment where, owing to low staffing levels, there is not always enough time to explain procedures and listen to service user choice. Furthermore, during periods when high numbers of service users are passing through, clinical interventions are seen as the only solution to low staffing levels and bed shortages.

### *8.5.3 The obstetrician's and midwife's influence on service user choice*

One key agreement between the two units is that the vast majority of service users, estimated by all interviewed from both sites to fall between 60% and 70%, comply with the advice given by the practitioner. Of the remainder, about 10% to 20% would choose minimal intervention or CAM[29] whereas the other 10% to 20% specifically request intervention in the form of induction, caesarean section, epidurals or some other form of allopathic pain killer. These estimated percentages, however, reflect the *expression* rather than the *realization* of service user's choice.

Both the 'analgesia' and the 'non-interventionist' cultures run across both sides of the caring divide, service user on one side of the fence and midwifery and medical staff on the other. For example, one Crighton consultant obstetrician preferred non-intervention and went on to explain how service user choice can overrule such an approach by, for example, requesting an epidural. The two units tend to vary in their approach to non-medical aids. TENS[30] machines and a birthing pool are freely available in Crighton, but, in Bingham, these need to be hired by the service user. CAM practitioners who are qualified and NHS approved may practice within the NHS but there seems to be little or no encouragement to increase this trend. Some midwives interviewed showed an interest in CAM, others were merely curious. Some

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[29] CAM: Complementary and Alternative Medicine. In the context of maternity care, these have been cited as: aromatherapy; reflexology; acupuncture; hypnotherapy; physiotherapy massage; water birth; the use of soft balls and TENS machines.

[30] *Transcutaneous Electrical Nerve Stimulation* A form of pain relief provided by a small box wired to electrodes which fix on to the skin.

practitioners see CAM as playing an important part in the future; others see it as merely transient, not destined to attain the same standing as orthodox treatment.

Anecdotes about service users who do not trust their health care practitioners came from both units. In Bingham, the refusal to go ahead with a caesarean section in one case reflected an objection based on religious grounds. In Crighton, one service user's refusal to accept any form of analgesia was based on the belief that an optimal birth is a natural birth. The service user's knowledge and understanding about maternity matters is often, though not always, inversely proportional to her desire for intervention. Knowledge, per se, is not enough, however, in a busy unit such as Crighton. A highly medicalised environment is not able to cope with the volume of service users without active interventionist management.

Abbott (1998:3) puts forward the supposition that the negotiable status of service users spells out the extent of professional power, adding, however, that "jurisdictional claims furnish the impetus and the pattern to organizational developments." The jurisdictional claim of the medical profession in Crighton's main obstetric ward impedes the full expression of service user choice whilst its organisational structure diminishes the full expression of the process-focused[31] role of the midwife. Whether the obstetrician is junior with the expected general skills, or senior with specialist skills, the general impression gathered is that the obstetricians' role and approach tends to be *outcome* focused; that is, their main priority and concern is that the end result is a live, and hopefully healthy, mother and baby. Since infant mortality is seen as an obstetric failure, obstetricians tend to concentrate their energies on the intrapartum period to ensure the survival of the newborn and the mother. Yet the *process,* the period between conception and post-delivery and the wishes of the service user before, during and after the birth has demanded increased attention in recent years. The Cumberledge framework is clearly related to both process and outcome, yet service user choice can easily take second place where the medical and clinical environment demands its own organisational tactics.

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[31] Pertaining to care from conception to post delivery.

Bingham on the other hand, presents a more balanced midwife cum obstetrician approach to the needs, if not the choices of the service user.

### *8.6 The impact of organisational and structural factors on continuity of care*

The document *Changing Childbirth* (1993) and its Scottish equivalent *Provision of Maternity Services in Scotland – A Policy Review* (1993) stress the need for a women-centred service offering choice, continuity and control during pregnancy, childbirth and postnatal period. Similarly, *A Framework for Maternity Services in Scotland* (2001), which supersedes the 1993 Policy Review, puts forward eight aims and 27 principles. Two of these aims concern user choice and continuity of care. The section headed 'Service Organisation and Provision', (Principles 18-21) puts an emphasis on accessibility, continuity and women's needs. Principle 19 states:

> Maternity services should adopt a holistic approach to care during pregnancy, childbirth and the postnatal period to maximise and improve continuity of care and continuity of carer for women.

The document does not lay down the ideal midwifery system but merely points to it.

> To provide continuity of care and carer: NHS Trusts should develop team, caseload or alternative models of midwifery care. It is expected that each unit would choose their own midwifery model tailored to meet the needs of local people and the needs of all healthcare professionals, with flexible working hours and family/employee friendly policies in line with the EC Working Time Directive and the European Convention of Human Rights (Scottish Executive 2001.)

All things being equal, fulfilling the needs of health care professionals should logically lead to service user satisfaction. Given the claim that it caters for both service user needs and the individual and domestic needs of the midwife, Bingham's culture comes close to this requirement were it not overshadowed by certain aspects of pay and other working conditions for team midwives.

Interviews with midwives from both units indicate that issues of choice and continuity are taken seriously. However, interviews with Bingham senior midwives/managers stressed how their team midwifery system is built around the

principle of continuity of care or caregiver. Some midwifery systems operate solely within a maternity unit, others function solely in the community, yet others, like the system employed at Bingham combine both hospital and community care. Integrated hospital and community care as such is not necessarily conducive to continuity of care or caregiver. For this policy to be effective, midwives need to work either on a one-to-one basis or within teams so as to give the service user the opportunity "to meet and know her delivery attendant." This is a key criterion identified by the Winterton Report (1992: para. 339). Studies such as the one by Wright et al. (1993) have shown that the achievement of this standard would also depend on the size of the team; for example, not more than six midwives in each team and that each team should have a defined caseload for whom it provides total care in all areas, according to the woman's needs.

One Bingham midwife who had been in service for over 25 years pointed out how new terminology often disguises the cyclical nature of maternity care provision, pointing out how team midwifery moved in and out of fashion since the sixties even if the term *team midwifery* was not official terminology forty years ago. The role of the integrated team midwife involves antenatal and postnatal care at the service user's own home or community clinic, parent craft classes and breastfeeding workshops as well as intrapartum care in hospital. Team midwifery has also been commended for its capacity to improve communication with other professionals e.g. GPs and health visitors. A key assumption underlying team midwifery is that a partnership between the GP and the midwife happens automatically, but "a lot of them (GPs) won't be open to change" (Bingham midwife). Another problem is that it is not always possible to match the GP surgery with the team area: for example, some GP surgeries service both Bingham and Warnick catchment areas.

Team midwifery is said to assist in increasing choice for mothers, to help increase the number of breastfeeding mothers and reduce the length of stay in hospital and therefore bed occupancy. Even if these advantages are not likely to be all present within one and the same maternity unit, the overall organisational efficiency at Bingham seems remarkable compared to Crighton where overall coordination is not

one of its strengths. This problem is related to the continual structural changes as much as it is related to the sheer size of the unit that often results in a heterogeneous approach to maternity care.

With its fragmented midwifery system and a high level of medical intervention, practitioners are likely to experience more stress and service user less continuity of care in Crighton compared to Bingham. Within the main labour ward, the duration of a midwife's shift does not always correspond to the duration of labour. The maximum length of labour normally allowed in the obstetric ward is,

> "probably about 24 hours because they would not let them go on longer than that once it's established. You have people contracting for days but not established labour and that's the difference. When they're roughly about 4 cm, when they're having regular, painful, rhythmic contractions that dilates the cervix - that's when labour starts (and since) most, on average, will have a twelve hour labour, us working twelve and a half hour shifts certainly allows for the *possibility* (of continuity of care)." (F Grade midwife, Crighton)

Team midwifery, on the other hand, has a much better chance of generating continuity of care throughout pregnancy *and* labour by a team of like-minded midwives.

The study of these two sites suggests that certain models of midwifery care can maximise or disrupt continuity. The chances of being delivered by a known midwife in Crighton are extremely low. In Bingham service users have a better chance of being delivered by a midwife they have met before. However, even here, the chances could also be limited as one midwife explained, "There aren't enough of us for it to be possible to guarantee that." Continuity of care requires a generous staff-user ratio.

In general obstetricians are outcome focused and perceive the intrapartum episode as more important than the ante and postnatal episodes. One obstetrician in Crighton views time spent on ante and postnatal care (the process) as excessive and therefore unnecessarily costly. Another consultant held that the number of visits could be reduced and decried the waste of resources when a community midwife is paid time

and travelling expenses to pay a 'social'[32] visit, which is what, he believes, a postnatal visit could amount to. In Bingham, however, *Changing Childbirth* (1993) is taken more seriously. Even consultant obstetricians, here, allow a modicum of balance between process and outcome to take place within a constrained budget.

### *8.6.1 Continuity of care and communication*

Bingham's ethos is also reflected in its communications system. Support for team midwifery by the four consultant obstetricians ensures good communication flows across the two professions. Each team keeps a special diary for writing in any identifiable problems and service users carry their own notes. This means that the user does not need to keep giving out the same information about herself to various midwifery, medical and other health professionals. Bingham also tries to ensure that vital information about service users is available through their electronic system[33] which holds their case notes.

Crighton's communication system may seem less stable and cohesive as one senior midwife explained,

> "We're looking at ways communication is passed. We have already started a communications book for staff who have been away for three days. They would be expected to read about the things that have changed since they were away and highlighted the things they must be aware of. They have a professional responsibility to find out for themselves."

Participants in both units put forward the view that in general midwives are better than medical staff at communicating with the service user.

> "The medical staff don't always take as much time. They don't communicate very well" (F Grade NDU midwife, Crighton).

Crighton's participants sent out mixed reactions as to how close a collaboration there is between midwifery and medical staff. Some asserted that the direction is changing

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[32] He described a social visit as one where a midwife shares a chat and a cup of tea with the service user and where there has been no substantial professional input.

[33] This is the MATSYST system which was created at this unit and was endorsed by the Scottish Executive for use in other units.

towards closer collaboration but also pointed out the shortage-of-time factor that obstructs midwives from attending case meetings with medical staff. Other reactions were more blunt.

> "I feel that there should be much more collaborative discussion and debate. And indeed the faculties in terms of medicine and nursing are poles apart and never should the twain meet" (Clinical Manager, Crighton).

Some obstetricians resist

> "working together with midwifery and nursing, sort of, on an equal basis" (Consultant Obstetrician, Crighton).

However, a different picture emerges from Bingham. A senior midwife asserted,

> "I think the reason why team midwifery is successful is because we've got consultants and a medical team who support us."

Findings suggest that even if the constraints imposed by economic rationalism were to be removed, continuity of care policy requires the cooperation of obstetricians. It is a strategy that demands the severance of the tribal barriers between the midwife and the obstetrician.

### *8.7 The gap between social health policies and practice*

*Changing Childbirth* (1993) brought about some cultural changes: for example, a higher degree of service user awareness of the clinical process because of her right to choose and to ask for information and explanation. Midwives in both Crighton and Bingham explained how women are treated much more like individuals now then before. They have "more say and are more outspoken about what they want." However, participants in both units agreed that only a small minority who have an NCT/AIMS[34] background and/or are 'well educated' are likely to choose actively or to question the health practitioner's course of action, whilst the majority of women

[34] NCT (National Childbirth Trust) and AIMS (Association for Improvements in the Maternity Services) aim to provide support and information about maternity care.

are more likely to accept the practitioner's advice. Women are often 'steered' in the direction of certain choices rather than others (Levy 1999, Ralston 1994). In this study it was possible to infer from participants' contributions that women's choices for ante, intra and postpartum care are shaped by the clinical environment.

Both sites reported how user choice may conflict with the practitioner's requirement to ensure safety and how the threat of litigation can be a controlling factor over the practitioner whereby exceptionally, service user choice takes predominance if there is a threat of litigation. This is a typical postmodern anomaly occurring in maternity care because, despite constrained resources, a caesarean section, which is both expensive and potentially harmful, is not always undertaken on medical grounds but arranged on demand if it means avoiding litigation. Currently, the soaring costs[35] of litigation nation-wide seem to defy the drive to be economically rational.

Expressing choice is not the same as having one's choice fulfilled. Apart from the practitioner's concern for medical safety, there are a number of limits to user choice. Participants from both units explained that the lack of resources and clinical pressures can inhibit the extent to which patient charters can be put into practice. It was clear that clinical pressure is more likely to take place in Crighton than in Bingham. This is due to size, organisation, and the midwifery system in place. However, it is an oversimplification to presume that the medical practitioners always opt to intervene or that service users always prefer low tech. Even in a place like Crighton, one, possibly exceptional, consultant obstetrician put forward the view:

> "I would reduce the choice of epidurals and things from the patient. It's impossible to do this in the present day and age. People have the choice but I think if you said that to the patients who want an epidural, then I hope you would remove some of the downsides of epidurals."

*8.7.1 The impact of low resources on 'customer sovereignty'*

One key feature of economic rationalism is the expectation of increased output for decreased input (Pusey 1991). In recent years, the need to change public services into

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[35] See Chapter five Section 5.3.1

"customised, convenient and cost effective organisations" has meant, "doing more with less" (ibid 1991). Both sites under study were experiencing a shortage of staffing resources when fieldwork was taking place. One participant in Crighton explained how adequate staffing levels could enhance choice: it would allow the extension of antenatal visits from ten to thirty minutes giving midwives time to explain the pros and cons of the choice a woman wishes to make. One Crighton NDU midwife felt that women were not necessarily being made aware of alternatives such as the option to deliver in the NDU or to have a homebirth[36]. The majority of women who deliver in Crighton do so in the main obstetric ward which is a cheaper option than homebirths. Service users who are aware of the NDU must fulfil very strict criteria before admission. Although the overall cost of giving birth in the NDU is expected to be less expensive than giving birth in the obstetric ward, admission criteria are likely to be influenced by safety issues as much as by physical constraints. The NDU houses only three beds. Although economic rationalism does dictate the overall staffing levels, it does not explain this anomaly. Crighton is a training hospital and, as such, encourages the greatest possible flow of service users to go through the obstetric ward for observation and training purposes. Therefore, the perceived needs and value system of the medical profession is as influential as the dictates of economic rationalism in shaping choices available to the service

Bingham is much less medically intensive than Crighton. Not being a training hospital, it has a lower medical practitioner to service user ratio[37]. A Bingham midwife indicated that choice can be manipulated by the GP or during parentcraft classes and that the clinical context and timing of the request can determine the extent to which a user can secure the choices she makes. In both units under study and in the general population, it is reasonable to suppose that around 70%[38] of women do not need an obstetrician during parturition. Yet, most, if not all, service

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[36] Homebirth requires at least two highly skilled, (usually Grade G) midwives who would have to give up their routine duties to attend a domiciliary delivery

[37] See Table 8.4

[38] See Chapter 5. Up to 71% of service users in Bingham did not need to see a member of the medical staff while in labour in 1999

users are likely to be seen by an obstetrician in a highly medicalised unit such as Crighton. This obstetric approach to maternity care is put forward under the pretext that it is not possible to discern who will require an obstetrician before the delivery has been completed and that, therefore, a high tech obstetric ward offers medical safety to all.

The provision of maternity care is undoubtedly constrained by low staffing/low skill levels on both sites, a situation that has an adverse impact on service user choice. However, medical authority can also be seen as another constraining (albeit life-saving in a small number of cases) factor that hinders the maximisation of service user choice. Findings suggest that the prevalence of obstetric authority over midwifery led systems varies depending on size of unit and its structural organisation.

Within maternity care, rituals such as filling in birth plans allowing the service user to clearly state her options are not substantiated in practice. More often than not women are expected to yield to the clinical environment and put aside their birthplan aspirations. Often the nearest hospital is far from the ideal especially if it is large and lacking the personal touch which most women about to deliver need and desire. The number of maternity care units which have merged into a central unit across Scotland in the last two decades is proof that the forces of EC/NPM can and do override service user needs and perspectives.

For both Crighton and Bingham adequate staffing levels is key to providing both service user choice and continuity of care. Only optimal staffing levels would make continuity of care and/or care giver possible; and even then, such provision cannot always be guaranteed. Staff and/or skill reduction is the most prominent feature of economic rationalism at work in both sites. Whilst the proclaimed merits of new public management are that it avoids waste and provides managers with a certain amount of control or the perception of control, critics (Hood 1995; Pollitt 1993; Pusey 1991; Walsh 1995) have pointed out that the implementation of social policies have been severely constrained in public sector environments dominated by economic rationalism.

### *8.8 Summary and Conclusions*

A comparative analysis of budgeting and finance in the two units reveals a more balanced approach towards financing social health policies in the smaller unit. The hyperunit proved to be less adept at operationalising the Cumberledge Report within its organisational structure and budgetary resources. One drawback at Bingham is the change in midwives' remuneration and working conditions so that team midwives seem to have taken the brunt of the severer outcomes of economic rationalism.

Whilst financial constraint has meant inadequate staffing skills and/or levels in both units, overall, economic rationalism has had a dissimilar impact on the two sites. The smaller unit found itself in a better position to take on board the recommendations of *Changing Childbirth* and was able to negotiate with health care practitioners to moderate the rigorous consequences of NPM. The cooperative clinical relationship between medical and midwifery staff at Bingham also goes a long way towards the implementation of *Changing Childbirth.*

The centralised maternity unit under study is better funded and better equipped than the smaller unit. However, in the larger unit, maternity care is likely to be a rushed event, often accomplished under stressful clinical conditions, whereas service users in smaller units are more likely to get some degree of continuity. "There used to be a lot of different smaller units and perhaps the care was more one to one and had more continuity, " informed one midwife who was moved to Crighton from a smaller unit. The advantage of merged units, according to another participant, is that they "are probably better funded."

Non-interventionist approaches to childbirth are less likely in the large unit. However, a strong medical orthodoxy in both sites is also evident through health care practitioners' approach towards CAM. Only a small minority of clinicians practice complementary and alternative treatments or would like to see more of these treatments in the wards.

In general, the obstetric culture predominates in large training units where the provision of service user choice and continuity of care and caregiver is very unlikely.

Findings give a strong indication that the authority of the medical profession and their pursuance of high obstetric technologies are influential factors residing outside the economically rational framework.

The key themes that distinguish Crighton from Bingham are closely linked to their organisational structure, size and their professional relations. The implementation of service user choice and continuity of care are clearly shaped by the clinical milieu. For this reason, EC/NPM regime has had a dissimilar impact on the two sites. In both sites, however, managerialism has diverted funds away from the provision of adequate staffing and skill levels. In Crighton, participants gave anecdotal evidence of the risks to service users owing to staff shortages when the ward is very busy. In Bingham, potential hazards stemmed from the recruitment of insufficiently skilled midwives.

Findings emerging from this study ultimately culminate to the conclusion that the goals of obstetrics and economic rationalism are major forces which conflict with socially desired maternity care policies such as those recommended in *Changing Childbirth* (1993). Ultimately managerial regimes have not only overridden customer sovereignty but have also made the implementation of social health policies even more difficult to achieve.

# Chapter Nine

## Conclusions

### *9.1 Introduction*

This study provides an empirically informed analysis of the impact of economic rationalism and new public management on maternity care provision. Whilst the two units studied are organisationally atypical and may not, therefore, represent other maternity units of similar sizes in Scotland, the comparative analyses gave a clear yardstick against which to measure participants' organisational freedoms and constraints within their respective settings. The comparison also permits insights into the interplay of internal cultures, midwifery systems and budgetary control, all of which have universal application. One key factor that is generalisable is that both sites are subject to the centralisation of services – a process which represents organisational change nationwide. One site is the product of several mergers and the other was in the process of merging with another during fieldwork.

The heart of this thesis is an exploration of how and in what way clinical action and perception, which is embedded within these structural changes, responds to social health policies recommended in the Cumberledge Report.[1] Has NPM had an adverse effect on the principles of service user choice and continuity of care as advocated in *Changing Childbirth*? A clear and straightforward answer to this question is clouded by a multiplicity of tensions. At one level, the adoption of a strong medical paradigm can hinder the proper implementation of social health policy; at another, traditional collectivist values have been particularly compromised in the arena of staff

[1] The Cumberledge Report and Changing Childbirth are employed interchangeably throughout.

employment and retention, and general working conditions. The latter constraint features strongly in the working conditions of Bingham's team midwives.

The impact of various ER/NPM tools such as devolved budgets, cost constraints, continual organisational turbulence, and the centralisation of services all restrain the call for increased attention to be given to service user choice and continuity of care. This thesis argues that the obstetricalisation of childbirth has become a powerful force despite the 1993 Cumberledge Report. The nationwide movement towards the merging of small units into larger ones, better equipped with the latest obstetric technological expertise, evince a strong obstetric influence alongside ER/NPM considerations. Whilst economic rationalism dictates that small and medium units cannot *all* be equipped with all the expensive latest technologies and accompanying obstetric expertise, the merging of services into large centralised units has clearly meant the triumph of technological determinism over traditional midwifery.

The comparative study shows that although the micro implementation of *Changing Childbirth* in the small unit is restricted by cost constraints, it has been possible to implement some social health policies owing to an organised professional will. In contrast, in the large unit, devolved budgets result in a certain amount of operational fragmentation, increased attention to cost consciousness, low staffing levels and ultimately a noticeably decreased concern for social health policy implementation. Findings emerging from this study culminate in the exposure of major gaps between the goals of obstetric care alongside the goals of economic rationalism and the goals of Cumberledge. Hill and Hupe (2002) suggest that implementers sometimes have difficulty in knowing not only how to implement a policy adequately but also what is to be implemented. This situation seems to be especially relevant in the maternity care arena with its multiplicity of competing policies and philosophies.

### *9.2. Contribution of thesis to present state of knowledge*

Maternity care is an exceptional health service insofar as the large majority of those for whom the care is provided are healthy women who come into hospital not to be treated or cured like a patient but to be assisted in a *natural* physiological process

(Second Report of the Maternity Services Advisory Committee 1982). For this reason, several official documents, including the Cumberledge report (1993), have insisted on the need to democratise these services, recommending that women are given control, choice and continuity of care.

One key contribution of this thesis is the identification of a number of causes that combine to obstruct the implementation of these social health policies.

*Firstly,* the historical outline of the transition from progressive public administration to NPM in chapter two and the literature review in chapter three indicate that the traditional collectivist values underlying social policies have been overthrown, to a great extent, by new managerialist ideas imported from the private sector. Using maternity care as a case study of a more general phenomenon applicable to wider health and welfare provision, it has been shown that certain aspects of managerialism do increase the gap between social health policy and practice.

*Secondly,* empirical evidence derived from the two sites reveals the complex economic, organizational and institutional difficulties involved when attempting to implement social health policies. It has been shown that in this arena, technological proficiency joins forces with obstetric expertise and despite the cost efficiency implied by economic rationalism, mergers are taking precedence over the retention of small low cost[2], low -tech maternity care units. Yet, mergers may not necessarily result in fiscal savings, at least not in the short term, and since new technologies[3] become swiftly dated, long-term savings become increasingly unlikely.

The merging of maternity services is an allegedly economically rational (and national) trend which overrides *Changing Childbirth* and ignores existing evidence[4] of service users' preference for small midwife-led units. Indeed, this study

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[2] Although the cost benefit analysis of several small low-tech units compared to one large high tech unit is highly disputed, there are several studies cited in previous chapters which indicate that small low tech units are more cost efficient to run.

[3] Often new medical technologies also require highly skilled specialists to operate them.

[4] Two trials (MacVicar et al. 1993 and Turnbull et al. 1996) found that the women allocated to midwifery units were more satisfied with their care than those allocated to consultant units.

corroborates with existing research that evinces that the clinical environment of the smaller units, as opposed to larger medicalised units, is more likely to bring about service user satisfaction.

The other important thematic contributions are listed in 9.2.1 to 9.2.5.

### *9.2.1 Clinical cultures*

The modus operandi of individual maternity units can also free or constrain the implementation of social health policies. For example, service users are asked to complete a birth plan. In both units, this procedure is regarded as a routine gesture that adds to the expectant woman's profile rather than a document whose directions are to be strictly followed. Whilst the vast majority of service users are willing to be guided by practitioners, a small minority insist on their pre-determined choices during the intrapartum period. Findings from the two units indicate that the practitioners' advice is dictated by their internal philosophies and distinct clinical culture, as well as resource availability. For example, only a very small minority of service users in Crighton could possibly give birth in the three-bedded Normal Delivery Unit at any given point in time.

### *9.2.2 New Public Management*

The diffuse set of management ideas imported from the private sector has also indirectly obstructed social health policy implementation. NPM has, in a number of ways, suppressed the traditional midwifery approach to childbirth by stealing practitioners' attention away from social health policy issues and squarely into economic efficiency through the encouragement of cost consciousness, devolved budgets and not least the resultant organisational turbulence.

### *9.2.3 Implementing Changing Childbirth*

Views about the implementation of *Changing Childbirth* varied amongst practitioners working in the same unit. These ranged from a keen enthusiasm to put policy recommendations into practice to one exceptionally downright criticism of the

report for upsetting the applecart and recommending the 'impossible'. By and large, practitioners in the hyperunit saw the Report's recommendations as impracticable owing to the lack of funds as well as the requirement of an organised aggregate resolve that is needed to accomplish its recommendations. The continuous enlargement of this unit, the fragmented role of the midwife, and the macro and micro agendas imposed by NPM have redirected clinicians' attention away from the recommendations of *Changing Childbirth.* However, within the smaller unit, the three practitioners, who held managerial and budget-holding mandates, took pride in their achievement; viz. the organization of seven teams of integrated midwives – a system, they assured, that maximises the implementation of Changing Childbirth.

### *9.2.4 Professional tribalism*

Midwives in both units tended to grasp the spirit of *Changing Childbirth* more wholeheartedly than did medical staff. The latter are more evidently concerned with final outcomes - a live mother and a live infant. This professional divide reflects distinct approaches to childbirth that are an important consideration. In a consultant unit where a strong obstetric approach may overshadow normal or midwife-led[5] births, the recommendations in *Changing Childbirth* lose much of their influence. Nevertheless, as has been demonstrated in Bingham, it is possible to reach a compromise despite competing clinical perspectives. In this unit, obstetricians and midwives work co-operatively to maximise continuity of care for the service user whilst providing a 'medically safe' environment.

### *9.2.5 Organisational factors*

In addition to the systems' embedment in economic rationalism and the trend towards the obstetricalisation of maternity care, organisational factors too can obstruct the implementation of policy into practice.

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[5] Traditional midwifery as opposed to obstetric midwifery

The gap between the policy outlined in *Changing Childbirth* and practice in the two units under study varies. Whilst *service user choice* is largely determined by health practitioners' available time and other resources, obstetric and midwifery protocol also comes into play with clinical priorities determining the general ethos of the unit's culture. In addition, the study shows that providing *continuity of care* depends on the midwifery system in place. The medium-sized unit with its seven teams of integrated midwives offers a reasonable degree of continuity of care compared to the large unit with its fragmented midwifery system.

There was no identifiable minimum or maximum degree of continuity of care that the units under study aimed towards. Whereas the medium sized unit aimed to organise its midwifery system to maximise continuity of care, implementing continuity of care in the hyperunit held a very low priority. Budget holders in the smaller unit tried to ensure that expenditure takes into account certain aspects of *Changing Childbirth* whereas budget holders in the larger unit were too dispersed to co-ordinate social health policy with service delivery. Thus, findings illustrate that the size, setting, and the midwifery system in operation can also increase or decrease the likelihood of social health policy implementation.

### *9.3 The implications for future social health policy*

Although maternity care is a specialist field, the way it is delivered raises issues that are general to many health and welfare services. In a way, maternity care is at the vanguard, where the engineering approach of modern medicine encounters the personal and emotional concerns of those it sets out to serve. Today, a growing number of women have clear ideas about how they want their delivery to be conducted – a feature noticeably encouraged by *Changing Childbirth.* This enquiry demonstrates that when social health policies are concerned with the personal and subjective needs of the service user, they can easily be pushed aside. In maternity care, the competing claims of economic restraint and the medicalisation of childbirth have a strong political sway, particularly in the hyperunit.

Significantly, *Changing Childbirth* is a free-floating document disengaged from any considerations of the costs required to fully implement its recommendations. What is missing from this document is some clear costing of the provision and outcome of service user choice and continuity of care in both the long and short term. Would the provision of appropriate care and support throughout the three episodes[6] and the resultant diminution of medical intervention save or increase costs? The accent on medical safety, which pro-centralisation documents clearly emphasize, is based on a negative approach to childbirth where crisis must always be a possibility. With such negative expectations, therefore, the need for medical intervention becomes a self-fulfilling prophecy, especially within highly stressed and poorly staffed clinical environments. The widespread obstetric approach to childbirth is based on mechanistic models of the body whereby women are discouraged from connecting to the natural processes of their bodies, conditioned to be fearful of childbirth and encouraged to put faith in disempowering clinical procedures.

The formulation of social health policy guidelines in tandem with other health policy documents could lead to a compromise between conflicting perspectives about best practice relating to pregnancy and childbirth. The outcome of such coordinated thinking and action for Bellham Trust could have been the retention of both Bingham and Warnick as separate maternity units, assigning one of them as a high tech unit and the other as a normal delivery unit managed entirely by midwives. Such an arrangement would have catered for the two distinct childbirth models[7].

Within the existing managerial framework, where the close monitoring of costs is paramount, the implementation on the Cumberledge Report has been put aside in favour of other perceived priorities. Medical safety, for example, has a wide appeal and since currently most births take place in hospital, the service user easily slips into the category of 'patient' as opposed to someone performing a natural and healthy function. As such, the universal need for medical safety, that seems to have crept

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[6]Ante, intra and post partum.

[7] The two distinct models are clearly outlined in section 9.4

stealthily into the service users' psyche, is now recognized as an important necessity. Thus, the requirement to merge units into medically safe, high-tech temples, irrespective of cost, has gained a wide appeal.

Whilst Baldock asserts,

> "It is almost a universal axiom of economics that a government should not intervene in an existing economy unless doing so will produce an efficiency gain or achieve some other goal that is valued above efficiency, such as some criterion of social justice. It follows from this that any proposed state activity, such as a social policy, or even any continuing activity, should be carefully evaluated for its likely costs and outcome" (Baldock 1999:99),

the merging of units seems to serve one main goal, the medicalisation of maternity care, at the expense of the recommendations in *Changing Childbirth* and the likely high costs involved.

Given that before the inception of NPM, services were not being executed optimally, does its onset improve or compromise the integrity of social and health policies even further? Findings suggest that NPM's ascendancy severely compromises the quality of maternity care as its requirements divert attention away from service user needs to economic, organisational and institutional demands. Whilst the rhetoric surrounding customer sovereignty, patient charters and service user rights implies the existence of a political will to democratise and enhance the quality of public services, the diversion of funds away from service users' choices and to predetermined universal provision nullifies the declared principles. The deep contradictions inherent in maternity care provision cannot be explained by reference to the economic paradigm or globalisation that is said to "deny national governments the space in which to construct alternatives to the neo-liberal orthodoxy" (Watson 1999). Findings suggest that financial resources are going to projects that decision makers arbitrarily consider 'good welfare' such as, the institutionalisation of obstetric safety. As Pusey (1991) puts it, "lived experience is virtually forbidden to speak."

As early as the late 1950s, Titmuss (1958:130) warned against allowing "technique to triumph over purpose", pointing out that not only does medical expansion

adversely affect the relationship between doctor and patient, but such observations serve to remind us that often it is *not* the need to satisfy people's welfare that has become too expensive but the relentless chasing after newer technologies and the creation of more specialisms that has become very costly. Titmuss points out that,

> "Many of these new needs are born of the dis-services of technological and scientific change which, in turn, give rise to new concentrations of self-interested professional and economic power" (ibid 1958:242).

In the construction and implementation of social health policies, two issues clearly emerge. *Firstly,* the benefits of certain activities[8] may be too complex to account for financially. However, this resistance to accountingization does not mean that they do not generate health gain and by indirect implication economic gain. *Secondly*, if spending on quality care and health gain is seen as a drain on resources, standards are likely to plunge along with the consequent costly loss of overall welfare.

### *9.3.1 Implications for health and welfare services*

Whilst the dictates of EC/NPM are implemented in diverse ways across the public services, this study demonstrates that at both macro and micro levels social health policies can be diluted/overlooked (Crighton), or partially implemented (Bingham), depending on internal professional agendas. Within the smaller unit, obstetricians and midwives were disposed towards a more positive response towards *Changing Childbirth,* whereas, within the larger merged unit, organising care around the provision of high tech treatments took precedence and ultimately influenced service user choice or service outcome.

Undoubtedly, the new importance given to management functions and the business-like approach to public service provision has upset the health care professionals' working conditions owing to continuous internal organizational changes. Moreover, the growth of service user rights has transformed their relationship with service

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[8] Such as care and emotional support during pregnancy and childbirth

users. As outlined in chapter two, the acceptance of these changes across most of the welfare services suggests that the old collectivist values have been abandoned in favour of stricter controls on spending and a more comprehensive form of financial management. This assertion has been substantiated empirically.

Features which other health and welfare services are likely to share with the maternity care setting are:

- Continual organizational turbulence
- Devolved budgetary systems
- Cost consciousness by those who deliver the services
- Harsher working conditions in terms of hours worked and remuneration gained (for many workers it has led to loss of past securities and an intensification of work demands)
- Poor or weak consultation procedures prior to major changes
- Increased red tape
- Increased demands made by service users
- A requirement for health care practitioners to be adaptive and to learn new skills.

The question as to whether or not the inception of NPM is reversing the traditional values underlying social policies (or, in this case social health care policies) can only be partially answered in the affirmative. The epistemological issues raised by this study indicate that several other factors, apart from the economic paradigm, are obstructing the execution of official social health policy recommendations. The extent of the implementation of *Changing Childbirth* varies from unit to unit because service user choice is economically and institutionally circumscribed whilst the provision of continuity of care requires further organisational complexities. Moreover, the merging of units means that medical technologies are increasingly shaping the nature of maternity care provision with the decreased likelihood of social health care policy implementation.

Fieldwork suggests that provision is moving in the direction of obstetric care with institutionally set parameters of choice for the service user whilst continuity of care is hindered by the low number of midwives and/or the cost of upskilling them or having them on call. These and other fiscal restrictions have, in some cases, inhibited the organisation of midwives into appropriately sized teams to ensure a high degree

of continuity of care for service users. Findings suggest that NPM procedures have not necessarily empowered the service user and seem to have disempowered a number of health care professionals by reducing funds whilst adding extraneous responsibilities to their clinical roles.

In the provision of maternity care, it has been shown that macro-policies, such as, the centralisation of services instigated by central government and which clearly influence local delivery in one direction conflict with social health policies which encourage local organisations to devise their own internal strategies in the opposite direction. For example, the micro-implementation of social health policies, such as *continuity of care* and *choice* resonate more strongly with the midwife's rather than the obstetrician's discourse. Therefore, they are procedures that are not easily achievable within a large centralised medical environment.

### *9.4 Towards an alternative model of social policy*

Since social concerns cannot realistically be divorced from economic considerations, an alternative model of social policy would encompass a broadened form of economic regulation which integrates "psychosocial issues into economic analysis" (Ryan and Shackley 1995). Accordingly, Mannion and Small (1999) list at least three problems with neo-classical approaches to the economics of health: (i) It is too exclusive or narrow in its approach. It fails to consider the social context in which economic action takes place and therefore needs to move beyond the individual; (ii) It speaks with one voice underlined by a unified language and value system and, as such, excludes any intrusion from unorthodox value systems; and (iii) It bases its assumptions on competitive and egocentric behaviour when in reality human behaviour can also be cooperative and altruistic. The implementation of social health policies, therefore, suffers in the hands of narrow health economic calculations.

Another narrow disciplinary approach that could benefit by bringing down its barriers is orthodox medical care. The conception of the human body as a source of "objective knowledge" and "essentially a material entity" to be used as a "basis for medical power" (Samson 1999), is scientifically and culturally opposed to the

conception of the human body as intrinsically linked to *subjective* emotional and spiritual dimensions which can have a bearing on physical health. These opposite philosophies have produced two polarized models of maternity care.

> (A) All deliveries are potentially critical; therefore, hospital is the safest environment for childbirth.
>
> (B) All women benefit from care, support and a cultivation of faith in their own bodies and that all medical intervention is potentially harmful.

The first model is linked to technological determinism triggering rising costs in the provision of maternity care. The second model is less costly and is marked by self-determination and self-management situating medical expertise at the periphery rather than the centre.

The development of an alternative paradigm of maternity care would:

(i) Take into account the pros and cons of both models.

(ii) Be based on a comprehensive form of health economics.

Accounting for social and subjective dimensions of health (Power and Laughlin 1991) would mean, for example, accounting for stress and factors that are likely to contribute to stress. An alternative model would account for non-tangible inputs and outputs so that health outcomes are comprehensively appreciated. A careful study of the costs[9] and benefits of types of treatment would try to include non-tangible[10]

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[9] For example, by including the estimated cost of unknown side effects of new technologies

[10] A number of non-tangible inputs may consist of: i. levels of stress on staff and ii. levels of emotional support given to service user. Non-tangible outcomes may consist of service user dis/satisfaction (post-natal depression/feelings of empowerment), midwifery job dis/satisfaction, un/successful breastfeeding; increased/decreased fetal distress and shorter/longer labours.

inputs and outputs. For example, a number of studies have shown that a lack of professional care and support during labour could lead to costly obstetric intervention. Sophisticated modelling can be utilised to measure the compounding effects of ignoring certain non-tangibles, for example by measuring the cost of toxicity and postnatal depression (owing to medical and clinical stress) on the individual and the community.

Mooney (1994) raises the question of who is to decide what is a legitimate inclusion as a health care resource. Would the values of medical experts, politicians, accountants, or service users prevail? A close examination of the present system reveals that it is largely influenced by the medical industry because medical interventions are perceived as intrinsically benign rather than 'a necessary evil'. If, however, they were perceived as the latter it would allow accounting systems to change dramatically to reflect this radical change in values (MacDonald et al. 1984). Moreover, findings suggest that some medical interventions are carried out due to stressed clinical environments – leading to unnecessary health loss and into a vicious circle of soaring medical expenditure. For example, an epidural assisted birth carries the possible risk of further intervention and, therefore, expenditure. In comparison, the cost of a natural birth is relatively minimal and more likely to result in long-term healthy outcomes. Moreover, interventionist treatments are registered as illusory health gains, whilst the capacity for women to deliver naturally is not valued at all despite the evidence that actual *health gain* lies in minimal or no intervention at all. Thus, accounting for natural births is a significant consideration.

There is a recognised need to account for the simultaneous action of rational and non-rational dimensions and the way non-tangible resources can effectively enhance the service. Pollitt (1986) argues that the managerial role needs to be broadened to take into account,

> "Wider issues such as quality of service, fairness and the degree of equity in its provision, the predictability of its provision and degree of democratic control must also be considered" (ibid 1986).

Pollitt explains that managers should account for:

i. Availability of services (in this case, it may be increased opportunity for a natural childbirth).

ii. User awareness of services (for example, broadening service user choice).

iii. Service user satisfaction (one measure of this factor could be continuity of care).

Such issues go beyond probity, economy and efficiency.

One anomaly, which an alternative model would need to address, is the relatively high cost of financial monitoring compared to quality monitoring. Interviews with finance managers, lay and clinical, revealed that the short-term financial approach towards achieving health care goals is paradoxically outweighed by a bureaucratic and administrative system that monitors financial flows. A fragmented approach splits social health issues from economic ones so that the system lacks a comprehensive policy design that encourages a coordinated approach. Policies, such as those outlined in Changing Childbirth (1993), are not aligned to other operational and strategic changes. The launching of social health care policies can easily be choked by rigid medical, financial and accounting structures leading to service users and health care practitioners having to confront incongruous impracticalities. Scientific knowledge, medical technologies, modern information and communication systems, and service users choices need to develop together and to inform organisational change. A unitary meta-policy, which is informed by broad multi-disciplinary concerns, could provide an overarching blueprint which co-ordinates dispersed legislative and policy guidelines.

The formation of an alternative model would require broadening the data collection frame. At present, hospitals are not obliged to collect beyond basic data such as: daily, weekly and monthly deliveries and whether such deliveries were forceps, emergency or elective caesareans; how many women had first, second or third degree tears and how many babies needed resuscitation. No information is collected about user choice, what proportion of service users insist on but receive no medical intervention whichever way this concept is defined.

> "We can identify who's had their labour induced and who's had their labour augmented. But that's not maternal choice. We don't carry information about maternal requests for augmentation and intervention" (Senior Midwife – Crighton).

The same is true regarding the collection of data about the number of service users who request the non-interventionist approach, or who wish to use complementary and alternative treatments. At present, no data is available which shows the number and type of requests and their outcomes.

An aspect of evidence-based medicine that could be incorporated into an alternative model, would include service user feedback, a practice that can be established through the creation of an electronic data bank that synthesises lay experience and medical expertise. Sound treatment and health care can be validly evaluated by the patient and according to Samson (1999) the subjective indicators of health are just as or more important than objective medical assessments. Moreover, as one consultant at Warnick admitted, the patient can often be more knowledgeable than the doctor about a particular medical issue because "they have more time to look it up and become thoroughly informed about it." Such a patient-doctor interactive process may be a radical step towards the translocation of established medical power and authority and might also hold the answer to many problems that confront the running of the health service.

An alternative model would:

- Scrutinise the claim that health legitimacy must be medically based and would closely examine all adverse effects
- Recognize that optimum use of resources and maximum outcomes can be derived by paying attention to non-tangibles as well
- Ensure that policy and management work together towards the achievement of health as opposed to the achievement of health care strategies
- Encompass a broad based transformation of economic reason and calculation (Power and Laughlin 1992), therefore, a shift from "quantitative growth to

qualitative maturation" (Henderson 1993) that allows for the appreciation of consumer needs (Pollitt 1986).

This thesis argues that a clear change in priorities, if not a wholesale change in values, is taking place within the public services, specifically within the maternity care services. The solution may lie in the inclusion of new and broader indices in economic evaluations (Henderson 1993) that would remove narrow claims to efficiency and effectiveness and, at the same time, allow health and welfare services to be democratized without compromising probity and economy.

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[4] The full title of this report has been changed to preserve anonymity

# Appendix 1

## Preliminary interview schedule - phase one

## Preliminary interview schedule - phase one

Thank you for agreeing to take part in this study. Can I first assure you that you will remain completely anonymous and no records of the interview will be kept with your name on them. This enquiry is about how budgets are translated into maternity care. I have decided to find out about this issue through a set of interlinking themes that relate to budgeting decisions in health care. These issues are:

A. Management styles

B. Staff policy and empowerment

C. Access to quality information, training and new technologies

D. Perceptions of 'standards of health care'

E. Application of new medical knowledge

F. Cultural differences and expectations of patients and staff

### *A. Management styles*

1. The Labour government's white paper *Designed to Care*, outlines the restructuring of NHS Trusts and puts forward the introduction of new bodies such as the National Executive for Clinical Excellence. As far as you are aware have recent changes had an impact on the pre-1997 management styles? Or do you anticipate any in the near future? (Probe *for how these changes are being executed by managers and received by staff and for reaction to restructuring at all known levels).*

2. Have changes in the last 10 to 20 years helped management to cope better with:

i. Rising demand of services; and ii. Decline in real resources (if such is the case)?

3. As far as you are aware does the overall effect of these changes mean a fall, or rise in the quality of services, or no change (or hardly any) whatsoever?

4. According to your experience, in what way are health care objectives expressed within existing organisational and managerial frameworks?

5. Would you say that the current managerial style constrains or frees maximum health care provision? (*Probe for rewards or penalties for those who refuse to conform to current managerial systems; probe for gap between medics' perception of effectiveness and management's perception of efficiency*).

6. How much freedom would you say you have over initiating new ideas to improve health care?

7. How well do you think organisational policies and activities adapt to local circumstances and needs?

Do clinicians perceive a fair balance between:

a) Managerial power and authority - and - public accountability?

b) Ethics such as equity, fairness, honesty, probity, altruism, trust - and - the three 'Es' of efficiency, effectiveness and economy?

c) Strategic choices such as identifying needs - and - strategic implementation such as cost reduction and increased productivity?

8. Do health care objectives always prevail over organisational and managerial concerns?

### *B. Staff policy and empowerment*

1. The 1989 white paper 'Working for Patients' (24:3:8) stated that 'performance-related contracts of employment will (...) provide strong incentives for hospital managers to improve the quantity and quality of the services on offer'. Has the contractual approach resulted in more precise delivery of outcomes? (*Probe for construction of labour force and design of work processes and extent to which staff are seen as assets or costs).*

2. How satisfied are you with your working conditions and environment? (*Probe for industrial relations; co-operation from management, colleagues, junior staff; own employment contract; apparent future prospects; work satisfaction; resource availability*).

3. Is there room for improvement in the organisation of teamwork? (*Probe whether swift and intense changes have radically changed the form of professionalism; probe for evidence of tribalism or whether contributions of other professions are valued*).

4. In what ways has the changing technology of work shaped the design, commission and delivery of services? (*Probe for budgetary issues and 'standards of care'*).

### *C. Access to quality information, training and new technology*

1. The National Institute for Clinical Excellence was set up to support clinical governance and to provide health professionals with guidance on clinical management. The institute is expected to undertake appraisals of new and established health techniques - including new drugs and procedures - taking account of clinical and cost effectiveness. They are expected to issue their advice to all doctors who will be expected to keep abreast of the guidelines. Sometimes the medical practitioners have to provide 'good reasons' for their diagnoses and treatment. Do you think tensions/constraints are more likely to come from management or from patients' complaints?

2. Are you usually consulted or merely informed about what you regard as key issues within your organisation? (*Probe for reasons*)

3. Have you been invited to attend any training sessions since May 1997?

4 When was the last time you attended training sessions? When are you likely to attend again?

5 Was training about structural changes; role and delivery of services; or about developing new skills?

6. Has any recent training changed perceptions of your role within maternity care and/or the NHS as a whole?

### *D. Perceptions of standards of health care*

1. What do you understand by quality in health care delivery? (*Probe for 'putting patient first'; access; appropriateness of services and outcome; cost-effectiveness, easy and efficient accessibility).*

2. To what extent is user participation included in the design and/or operation of the Quality Assurance System?

### *E. Application of new medical knowledge*

1. How are competing forms of treatment (traditional, alternative and latest technology) handled? (*Probe for who has the final say*).

2. To what extent does affordability interfere with the application of new medical knowledge/ technologies? (*Probe for solid examples*).

3. Can you think of ways in which medical and scientific breakthroughs can be better managed in the future? (*Probe for cost-effectiveness, affordability and benefits of treatment*).

### *F. Cultural differences and expectations of staff*

1. As administrators of health legislation, doctors and nurses are the mediators between the state and the citizens. To whom do you believe you are accountable? (*Probe for role conflict: concern for individual patient versus concern for wider public and regard for management versus own medical expertise*).

2. Would you say there is a coherent understanding of 'standards of health care' in your section? (*Probe for different philosophies and value systems*)

3. Have you ever come across divergent views of what health care delivery and/or

outcome should consist of from patients?

4. Are patients given choices? What kind of choices? In what kind of instances?

5. Any other additional comments? (*Probe for enhancement of management practices; resource reallocation; priority setting; performance indicators; handling complaints/grievances; setting of standards.)*

Full title/ designation: ..... No of staff responsible:.....

Dept./Ward size: .....

Length of service NHS: .....

Brief description of role and responsibilities:

# Appendix 2

## Interview schedule - phase two

## Interview schedule - phase two

Adjusted according to designation:

(i) budget-holders; (ii) midwives; (iii) senior midwives; (iii) junior doctors; and (iv) consultants and other senior health care practitioners.

### *Main budget holder*

1. Could you give me some indication of the number and type of practitioners your budget is responsible for?

2. Could you give me an outline of the budgetary process at the operational level?

3. Could you give me an outline of your budgetary responsibilities? (amount, area)

4. What does your budget include: staff, equipment etc.?

### *All budget holders*

1. What would you say are your budgetary priorities?

2. Is it possible to identify the collective priorities of your unit?

3. If spending on your programme were to be increased by £200,000 pa, what would you spend it on?

4. And what would be the effect in terms of both services and health?

5. And if spending were to be reduced by £200,000 pa what would go, and what would the effect be in terms of services and health?

6. What are the advantages/disadvantages of ensuring service user *choice* and *continuity of care* from the cost perspectives?

7. Are you responsible for incurring expenditure as well as generating or collecting

income? (*Describe main channels and avenues of these).*

8. To what extent do you find the present budgeting system satisfactory?

9. How would you envision a better financial management system?

10. How much financial decision-making relates to your own individual decisions?

11. I would like to ask you about restrictions and freedoms. To what extent does the system allow you to take creative risks in order to allow you to enhance your financial position; to enhance services; to enhance health? What risks would you take if you were permitted?

12. What about restrictions?

13. Are you associated with any organisation or interest groups such as NCT who might have an opinion about these issues?

14. Are there any blind spots that you think finance authorities might have and which may improve/restrict your own finance administration/management?

15. Would training of CAM practice be considered? What are the obstacles?

16. Are such therapies seen as cost cutting in the long run?

17. Do you feel restricted about such decisions?

18. How are such decisions reached? *(process)*

19. What sort of outcomes would you like to see?

20. How would you say the larger finance picture (e.g. higher pay awards; new drug development etc.) impact on your own individual budget?

21. Would you say that shifting values in the delivery of maternity care has shifted spending priorities?

### *Midwives*

1. In your opinion, has maternity care provision changed over the years? (*Probe: has it become more client-based? Requests for alternative/complementary therapies?)*

2. Do you think maternity care is becoming more or less stressful compared to say five, ten, fifteen years ago? If more stressful, would you agree that this means more stress for the service user too?

3. As a midwife how skilled are you in i. suturing; ii. top-up epidurals; iii. induction; and iv. venepuncture?

4. Do you see any problems arising as a result of clinical governance and the need for evidence-based medicine and or do the two work smoothly together?

### *Choice*

5. What proportion of births are entirely midwife led?

6. What would you classify as medical intervention? (*Probe: ARM, analgesia, etc.*)

7. In general, are women more likely to request intervention and medical examination rather than alternative/complementary/natural treatments? Or both equally?

8. How much use is made in this hospital of alternative and complementary therapies?

9. Is the hospital equipped with:

   a. TENS [Transcutaneous Electrical Nerve Stimulation] machines?

   b. Birthing pool?

   c. Soft Balls?

9. Who would decide whether to increase or decrease such equipment?

10. When was such equipment last installed or added?

11. How keen are you to learn more and be trained to incorporate alternative therapies alongside conventional treatment?

12. Do you think midwifery could make more room for alternative and/or complementary therapies?

14. Do you think that alternative and/or complementary therapies are more likely to be accommodated in the near future?

13. Emphasis on control over clinicians' decisions, activities and outcomes are meant to be reconciled with the trend towards patient de-control. How easy or difficult is this to achieve in practice?

14. How often would you say you are involved in clinical trials? Would you like to comment on results?

### *Cost effectiveness*

15. Are there any aspects of your work that are not costed yet can save money?

16. Do you see a corresponding relationship between cost cutting and evidence-based medicine or do the two sometimes operate in opposite directions?

17. Can you identify any positive or negative effects of cost cutting on i. the service user and ii. your role as clinician? (*Probe for stock/equipment levels; staff levels*)

18. Has maternity care been re-defined as a result of cuts or changes in resources?

19. Are you aware of a cost-consciousness culture, if so when did you first become aware of it?

20. Have you ever taken any initiatives toward cost cutting?

21. In what way do you think current organisational changes, such as managerial

structures, impact on cost effectiveness?

### *Continuity*

24. In what way do you think current organisational changes, such as managerial structures impact on the continuity aspect of maternity care?

25. In what way do you think current organisational changes, such as the merger with Warnick/Bingham, will impact on the continuity aspect of maternity care?

26. Tell me about your system of keeping computer records. Does this help continuity of care in any way?

### *General*

30. How well informed do you feel you are about future plans for the organisation of maternity care?

31. How well does communication flow between i. clinicians and users; and ii. clinicians amongst themselves iii clinicians and junior/senior colleagues? (*Probe for quality of information)*

### *Bingham participants*

23. Continuity is a very important goal of maternity care services. How does maternity care provision at Bingham ensure that users receive continuity of care? How feasible is it within the existing Team midwifery model?

27. How satisfied are you with the team midwifery system in place at Bingham?

28. In what way do you think current organisational changes, such as the merger with Warnick, will have an effect on i. maternity services; and ii. your job satisfaction?

22. In what way do you think organisational changes, such as the merger with Warnick will impact on cost effectiveness?

29. Do you have any anxieties about the pending merger?

*Conclusion*

32. Would you like to add any comments on current working conditions and their impact on standards of maternity care?

33. Can I ask you if there is anything else you wish to add or change to your earlier comments?

Thank you very much for helping me with this study and for giving up your time.

Full title/ designation: .....No of staff responsible for: .....

Dept./Ward size: .....

Length of service NHS: .....

Brief description of role and responsibilities:

# Appendix 3

## National Grades for Midwives

## National Grades for Midwives

**I** - Head of Midwifery

**H** - Speciality Co-ordinating Midwife

**G** - Senior Midwife

**F** - Experienced Midwife

**E** - Experienced Midwife

**D** - Newly Qualified

**C** - *Removed* -

**B** - Untrained/ Unqualified

**A** - Untrained/ Unqualified

# Appendix 4

## Technical aspects of finance and budgeting[1]

[1] The information in the pages which follow was sourced from a number of Bellham Trust and Craighill Trust documents. The full references are omitted to ensure anonymity.

## Technical aspects of finance and budgeting

### *External Financing Limit (EFL)*

The National Health Service in Scotland Management Executive sets an annual External Financing Limit. The EFL requirement for a year is arrived at by calculating the difference between internally generated resources (surplus on income and expenditure account for the year, depreciation, disposal proceeds and movement on working capital balances) and the Trust's approved capital expenditure.

A Trust can be given an EFL which is positive, negative or zero. A positive EFL is set where the Management Executive has agreed capital spending for a Trust which exceeds internally generated resources, resulting in the Trust needing to borrow or reduce investments in order to finance its spending programme, and loan principal repayment. In the case of a negative EFL, internally generated resources exceed the agreed spending programme and some or all of these resources must be used to make additional loan repayments or be invested.

During the year, the Trust, in reviewing its finance, may negotiate with the Management Executive to either increase or decrease its External Financing Limit. This is called "delegated end of year flexibility."

### *Financial Performance*

NHS Trusts have three financial targets to meet. They must:

- Achieve a 6% return on net relevant assets
- Break even on income and expenditure
- Operate within their External Financing Limit (effectively a borrowing limit)

*Capital investment*

The redevelopment of Maternity, Paediatric, SBCU and Gynaecology accommodation at Bingham.

*Revenue Costs*

- Redevelopment of Maternity, Paediatric, Gynaecology and SBCU accommodation at Bingham - capital charges costs.
- Savings associated with the decommission of Warnick's Maternity block and the demolition of Bingham's hutted accommodation.
- Capital charge savings - The maternity block is to be re-valued at Open Market Value (OMV)
- Additional cost of an Anaesthetic rota at Bingham for 24 hour Epidural service.
- Possible increase in Maternity centralisation savings due to the previous costing including an element of EPAU, which distorts the average cost per bed to a lower figure.

# ▪ Appendix 5

## The development of Maternity Care

## The development of Maternity Care

Midwifery attained legal recognition as a profession with the passing of the first Midwives' Act in 1902. This piece of legislation made provision for the training and registration of midwives. Later the Maternal and Child Welfare Act of 1918 encouraged the growth of salaried and subsidised midwifery services and the establishment of antenatal clinics in existing maternity centres. But provision was not mandatory and the growth of municipal maternity services throughout the country was uneven. For independent midwives, new antenatal clinics posed a threat. If they referred their patients to a clinic for advice, there was a possibility that an institutional confinement might be recommended and the midwife might lose her fee. The institutional confinement rate in England and Wales rose to 15% by 1927, to 24% by 1932 and to 36% by 1937. But maternal mortality rate still stood at 3,000 deaths per annum (Robinson 1990).

The 1936 Midwives' Act made provision for a salaried service under the control of supervisory authorities. The period between the 1936 Act and the 1948 NHS Act saw the heyday of the domiciliary midwife and the small maternity home. Midwives provided antepartum, intrapartum and postpartum care but participated much more in the work of the municipal ante-natal clinics. By 1946 the institutional confinement rate had reached 54% and correspondingly, the proportion of midwives in institutional as opposed to domiciliary employment also rose, reaching 31% by 1944 (Robinson 1990). In both environments midwives continued to be responsible for the care of the majority of women who experienced a normal pregnancy, labour and puerperium.

By the end of the war about one in three GPs was involved in maternity work. Following the National Insurance Act of 1911 that had guaranteed them remuneration for other work, many GPs tended to leave maternity work to midwives. Conversely, consultant obstetricians gradually increased their role and influence in the maternity services, particularly towards the end of the 1920s. The College of Obstetricians and Gynaecologists was founded in 1929 and possibly earlier. From

1930s onwards obstetricians advocated an increase in institutional confinement and maternity schemes based on large sixty to seventy-bedded hospitals. They also argued for a 70% institutional confinement rate with the maternity services in each area focused on a large hospital under the overall leadership of a consultant obstetrician. Obstetricians sought to curtail independent clinical judgment by midwives:

> "Midwives should not be regarded as competent to undertake unaided the antenatal care of the expectant mother, but should always work in collaboration with the general practitioner or the obstetrician" (Policy statement published in 1944: Royal College of Obstetricians and Gynaecologists).

The transformation of midwifery into scientific obstetrics is clearly illustrated by Schwarz (1990) who points out how successive editions of obstetric textbooks underwent a dramatic transformation as obstetricians asserted their authority over this field of expertise. Significant changes in content and semantics are revealed in the way the pregnant woman became a pregnant patient assisted by the obstetrician and the job of midwifery became the practice of obstetrics. The terms midwifery and accoucheur were replaced by the terms obstetrics and obstetrician.

The tug of war between midwifery and obstetric supremacy continued when in 1941 the Midwives Institute became the College of Midwives following an award of its own charter. By the 1950s, the midwife was the most senior person in approximately three to four of all deliveries (Central Midwives Board, Annual Report, 1963). Under the provisions of the 1946 Act, maternity care was provided by all three branches of the new service: hospital services, domiciliary services and GP services.

Between 1953-70, midwives and GPs seemed to work well together. The proportion of GPs providing antenatal care rose rapidly by the end of the 1950s. They gradually took over the provision of community antenatal care from the local antenatal clinics. At the same time midwives continued to provide antenatal care in women's own homes, at local authority clinics, and increasingly at GPs surgeries.

The period 1960 - 1970 was a decade of constraint for midwives. As medical staff

became increasingly involved in normal maternity care, the midwife's independence in assessing and monitoring the course of pregnancy, labour and the pueperium gradually diminished.

The 1959 Cranbrook Committee recommended the provision of 70% of confinement to take place in hospital. Later in 1970, the Peel Committee recommended a further increase to 100% as in its view hospital delivery afforded greater safety for mother and baby (DHSS 1970). The report of the sub-committee on *Domiciliary and Maternity Bed Needs* recommended:

- Centralisation of services under the control of consultant obstetricians
- GP maternity beds to be situated within or close to consultant units
- Consultants should have overall responsibility of the beds
- All women, whenever they delivered, should be seen by a consultant obstetrician at least once or twice during pregnancy.

In order to provide further antenatal beds, pressure to discharge women before the stipulated ten days after delivery were set in motion. Midwives objected to this. By 1970, 51% of total births were discharged before ten days rising to 91% by 1979 (Central Midwives Board, Annual Report, 1979/80). Antenatal care became fragmented between hospital and community staff. As birth rate and individual confinement rates rose, hospitals became less and less able to provide antenatal care of women booked for hospital delivery. Many areas moved to a policy of sharing antenatal care with community staff. These changes fragmented the continuity of care by midwives. At the same time the work of hospital midwives became subject to increasing specialisation.

In 1968 approximately a quarter of all midwives were, at any one time, working on one aspect of care (DHSS 1970). Such policy changes meant lack of continuity of care and curtailment of midwives' freedom to exercise their clinical judgment. DOMINO deliveries (providing continuity of care) were in operation as well but constituted a very small proportion of deliveries. Obstetric interventions began in the

1960s and climbed sharply in the 1970s. This meant fewer and fewer deliveries were managed entirely by midwives. At the same time an increasing number of units developed policies for the 'active management' of labour. This meant that staff were required to follow directions regarding frequency of vaginal examinations, when to rapture membranes and length of time to be allowed for the second stage of labour.

In recent decades both midwives and GPs have ceased to play an important independent role. Instead, consultant obstetricians have taken over the ultimate responsibility for childbirth. The use of various conventional surgical techniques like Caesarean sections, episiotomies and instrumental deliveries reached unprecedented peaks and a whole array of novel technologies such as intrapartum maternal and fetal monitoring devices were widely introduced into obstetric practice (Macfarlane and Mugford 1984). Medical staff became increasingly involved in the antenatal care of women with normal pregnancies, and many midwives' units were closed down. Labour became only normal in retrospect thus overshadowing the role of the midwife.

But the 1974 Health Service re-organisation resulted in the hospital and community midwifery services of each area being brought together into a single Midwifery Division under the leadership of a Midwife. In the 1980s, in an attempt to restore professional independence, midwives set up schemes that made full use of their knowledge and skills such as re-establishing midwives clinics and delivery suites in which the intrapartum care of low-risk women was provided by midwives alone.

Further changes in Health Service management, particularly those following the Griffiths Report (DHSS 1983) generated concern about the extent to which the profession was controlled by its own members. In particular, the integrated midwifery units established under the 1974 re-organisation came under threat. In some districts, hospital and community midwifery services were separated and then incorporated within other units of management. In others, midwives were placed in a position of accountability to nursing rather than midwifery managers. Intensive campaigns were waged by midwives in some districts to prevent these changes and in some cases they met with success. In 1992, the House of Commons Health

Committee commented that:

> "... the services provided by GP Maternity Units ... provide a model of care ... which approaches more nearly the ideal that we have already described" and recommended that " the policy of closing such units on presumptive grounds of safety be abandoned forthwith" (Maternity Services para 311-312).

This shows, once again, that it is political rather than health care considerations which have dominated the history of maternity care services.

Today midwifery is once again facing the process of reformation. The role of the midwife is once again undergoing changes largely due to political processes outside midwives' control. The move toward community midwifery is seen as key to achieving improvement in the health of both mothers and babies and is meant to be of real benefit to women in deprived communities where poverty, diet, smoking and other factors have a direct influence on the health of both mothers and babies. Taking services to mothers is meant to ensure the highest quality of care both before and after birth. Community midwifery is meant to provide the organisational framework, which balances the legitimate expectations of women with safety considerations and costs and has regard to geographical, social and other environmental factors.

This study found, however, that even where community midwifery is practiced, thorny issues such as the level of midwifery skills, and the medicalised environment of hospital births (where the majority of births take place) pose special problems. The recommendations listed on policy documents, therefore, are vastly diluted in practice.

# Appendix 6

## Bellham Trust: the merger of Bingham and Warnick

## Bellham Trust: the merger of Bingham and Warnick

### *Introduction*

Bellham Health Board has an overall responsibility to assess the health needs of its population (approximately 275,000) along with the Bellham Trust which employs around 4,000 staff and currently has around 844 beds. Bingham and Warnick maternity units which are directed by Bellham Trust have a long and distinguished history, with a clearly separate identity and a distinct sense of belonging for the people in their respective catchment areas. However, in line with the 1997 Government's White Paper, *Designed to Care*, Bellham Trust was formed from the Bingham Acute Services Trust and the Warnick Acute Services Trust on 1 April 1999. The rationale underlying the merger of the two Trusts is based, inter alia, on the opportunity this is expected to offer: (i) to move away from the previous competitive environment and towards a merged policy for acute services healthcare provision; and (ii) the two hospitals the opportunity to work more closely together so as to make the best use of their skilled staff and facilities.

In its *Draft Initial Agreement*[2] (April 2000), Bellham Trust stated its commitment to provide equality of treatment and opportunity for staff. The establishment of the new Trust led to the necessity of bringing together all the staff policies and procedures in operation and to create a programme of work with the Partnership Forum[3] to progress this issue. This has concentrated effort on the most critical areas where practice differs across the two sites. One such area is Maternity care provision.

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[2] The full title of this document is excluded from the bibliography to ensure anonymity.

[3] A standing committee of the Partnership Forum is meant to consider the way forward in respect of the development of a "Learning Together" strategy. This work involves the fullest examination of the Trust's utilisation of training resources, ensuring equity and appropriateness of access.

*Amalgamating Bingham and Warnick*

Maternity Care in Bellham is provided mainly in two District General Hospitals, located 12 miles apart, one in Bingham and the other in Warnick. Both maternity units have 1,600 to 1,700 deliveries per year and the majority of women opt to have shared antenatal care: this is provided by the GP/midwife with minimal hospital consultant appointments.

The model of care provided at Bingham Royal Infirmary is integrated midwifery care. This means a full hospital based midwifery service with integrated community midwives who are GP attached covering fourteen areas. Women are booked in their own home. Antenatal, postnatal care and parenthood education are given in the community setting. Midwives also provide care in a satellite hospital clinic. Unlike midwives at Bingham, most midwives at Warnick are not likely to be comprehensively skilled, work within a traditional shift pattern and have working conditions and pay in line with national practice. The Warnick system uses the named midwife concept.

The team midwifery system set up at Bingham in 1996 contrasts strongly with Warnick.

Summary features of the maternity unit at Bingham Royal Infirmary:

- Effective shift pattern with overlaps ensuring communication within and across teams and thus continuity of care
- Integrated (combining hospital and community) care
- Holistic care - with comprehensively skilled midwives
- Flexibility of working conditions/shift patterns within teams
- Named consultant for each team
- Service user belongs to a particular team consisting of around 8 named midwives and one named consultant

- Claims to be practitioner-led, patient-focused and protocol-driven.

In July 2001, it was decided to develop two new centres of excellence, one for surgery to be based at Warnick and the other for Women and Children's Services to be based at Bingham. The decision was made to opt for a centralised service with one site for all maternity-linked activity. All hospital deliveries would be concentrated in a new Women's and Children's Unit in Bingham. This Unit would provide inpatient maternity services, inpatient gynaecology, inpatient children's medical services, inpatient children surgery, day care assessment and treatment facilities. Full integration of maternity care staff and hospital equipment on one site are expected to take place over the next five years. The amalgamated maternity services are now headed by a clinical head, the former clinical director at the Bingham unit, a general manager, the former clinical co-ordinator at the Bingham unit and a nurse manager - the former senior community midwife at Warnick.

Bringing the two maternity units together would, according to the deputy director of finance of the Bellham Acute Hospitals NHS Trust, bring about savings insisting, however, that the main objective of the exercise is driven by quality considerations as well as the fact that a sufficient number of staff are not available to resource both sites.

Whilst the organisation of midwifery services in Warnick and Bingham have, up until recently, operated within distinct maternity care cultures, the level of services provided in each Unit are very similar - the only exception being a better-equipped paediatric unit in Warnick. See table Ap6.1.

**Table Ap6.1 Bellham Acute Hospitals NHS Trust**

| | Bingham | Warnick |
|---|---|---|
| Antenatal, intrapartum & postnatal inpatient care | yes | yes |
| Outpatient provision | yes | yes |
| [Antenatal Consultant Clinics, Midwives Clinics, Prenatal Diagnosis Clinics, Obstetric Scanning and Parenthood Education] | | |
| Day-care and Early Pregnancy Assessment Service Unit | yes | yes |
| Genetic Liaison Service | yes | yes |
| Combined Clinic for pregnant women with medical problems | yes | yes |
| SBCU - Special Baby Intensive Care beds | 0 | 5 |
| Intensive Care Unit - special care beds | 12 | 10 |

### *The rationale behind centralisation*

The official economic and medical reasons given are that by working together, the two maternity units would be in a better position to attract new resources and expertise, and would guarantee that the people who live in the Bellham area would have the very best in medical care when most needed and in the setting where it can best be provided (Final Report of Maternity Services Project Group[4] January 2000).

National guidelines suggest that a minimum of 3000 annual live births is required to maintain a viable obstetric and neonatal unit - hence the requirement to merge. Owing to a falling birth-rate which is reducing the volume of activity, teaching and

[4] The full title of this document is excluded to ensure anonymity.

training are seen to be further compromised. Directives on hours worked for junior medical staff are now more stringent, and again this difficulty is augmented. Since patients' expectations have risen with passing years, babies born unexpectedly and prematurely are expected not only to survive but to always do so unscathed. The input of senior medical staff both in the labour ward and in Special Care Baby Unit (SBCU), which is perceived as essential to such survival, cannot now meet the national recommendations and patient expectations (Maternity Services Advisory Group Report[5] 1997). These problems apply not only within maternity services but also to services providing vital links.

Another point made by the Maternity Services Advisory Group Report (1997) is that the provision of a dedicated obstetric anaesthetic service would only be achievable when a fully comprehensive maternity service is provided on one inpatient site. However, the official rationale for a centralised maternity unit tends to 'gloss' over the cultural resistance posed by the merger viz. a tug of war, hyped up by the media, over which site ought to "win" the new maternity unit.

A document entitled Preferred Location of Maternity and Paediatric Services[6] (2000) states that the location criteria aims at (i) maximising health gains for the population of that area based on relevant measures of health and service demand; (ii) ensuring the safety for mothers during delivery can be sustained; and (iii) having healthier babies in future in that area. On this basis, it was decided that the inpatient elements of these services should be located in Bingham whose population has a greater concentration of socially deprived areas and where mothers and babies are more at risk. Again, an analysis of the population showed that the current and projected numbers of women in the 15-39-age range are highest in the Bingham area. This is also reflected in the highest number of births, both actual and projected in this area (Preferred Location of Maternity and Paediatric Services 2000). Nevertheless, the

[5] The full title of this document is excluded to ensure anonymity.

[6] The full title of this document is excluded to ensure anonymity.

accuracy of these figures has been disputed - with one interviewed consultant obstetrician claiming that figures were dated and based on the 1991 census.

Since the vast majority of the population live within thirty minutes travel time of both hospitals, distance was not considered a significant factor. The long-standing difficulties relating to emergency paediatric input which is lacking in Bingham is one of the strongest basis used officially to rationalise merger. At the same time, the existence of a fully equipped paediatric unit in Warnick did raise expectations by staff that the new maternity unit would go to Warnick rather than Bingham

# Appendix 7

## Budget statements ~ Crighton Maternity Unit

Parameter Set Name A1 Period 10/1999

Cost Centre : WOMAN
Cost Centre : NEONAT

| Account | | Annual Budget | YTD Budget | YTD Actuals | YTD Variance | Period Budget | Period Actuals | Period Variance | Estab-lishment | YTD WTE | Curr WTE |
|---|---|---|---|---|---|---|---|---|---|---|---|
| TOTEXP | TOTAL EXPENSE | | | | | | | | | | |
| SALARIES | TOTAL SALARIES AND WAGES | | | | | | | | | | |
| 4874 | LOCUM - SENIOR HOUSE | 0 | 0 | 2640 | -2640 | 0 | 697 | -697 | 0.00 | 0.00 | 0.00 |
| 7023 | HOUSE OFFICER | 0 | 0 | 1592 | -1592 | 0 | 0 | 0 | 0.00 | 0.10 | 0.00 |
| 7070 | STAFF DOCTOR | 0 | 915 | 25931 | -25016 | 92 | 0 | 92 | 0.00 | 0.60 | 0.00 |
| 7114 | NURSE CLIN. SCALE H | 57873 | 48227 | 46303 | 1924 | 4823 | 4594 | 229 | 2.00 | 1.86 | 1.91 |
| 7115 | NURSE CLIN. SCALE G | 350646 | 291464 | 283244 | 8220 | 29591 | 29127 | 464 | 12.65 | 11.82 | 12.26 |
| 7116 | NURSE CLIN. SCALE F | 800296 | 666913 | 511208 | 155705 | 66691 | 53072 | 13619 | 29.18 | 22.41 | 23.97 |
| 7117 | NURSE CLIN. SCALE E | 929132 | 777054 | 607698 | 169356 | 76039 | 64901 | 11138 | 42.93 | 31.78 | 34.15 |
| 7118 | NURSE CLIN. SCALE D | 267600 | 223000 | 267846 | -44846 | 22300 | 32981 | -10681 | 13.50 | 16.37 | 20.07 |
| 7199 | NURSING REGISTERED OT | -70000 | -58333 | 0 | -58333 | -5833 | 0 | -5833 | 0.00 | 0.00 | 0.00 |
| 7212 | STUDENT NURSE-PS2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| 7311 | NURSING AUXILIARY-A | 110568 | 92140 | 73668 | 18472 | 9214 | 7605 | 1609 | 8.00 | 6.44 | 6.54 |
| 7315 | NURSERY NURSE - B | 49831 | 41526 | 32173 | 9353 | 4153 | 3463 | 690 | 2.83 | 1.98 | 2.18 |
| 7402 | CLIN. SCIENTIST - B | 28582 | 23119 | 30766 | -7647 | 1683 | 2669 | -986 | 1.00 | 1.00 | 1.00 |
| 7517 | M L S O - 1 | 13659 | 11382 | 7165 | 4217 | 1138 | 1709 | -571 | 1.00 | 0.40 | 1.00 |
| 7758 | A & C GRADE 3 | 14988 | 12490 | 9998 | 2492 | 1249 | 1063 | 186 | 1.00 | 0.94 | 1.00 |
| 7759 | A & C GRADE 2 | 18971 | 15809 | 15720 | 89 | 1581 | 1385 | 196 | 1.82 | 1.74 | 1.44 |
| 7774 | SENIOR MANAGER 4 | 35385 | 29488 | 29700 | -212 | 2949 | 3347 | -398 | 1.00 | 1.00 | 1.00 |
| MEDAGCY | AGENCY JUNIOR MEDICAL | 0 | 0 | 10865 | -10865 | 0 | 2506 | -2506 | 0.00 | 0.01 | 0.14 |
| MEDCON | CONSULTANTS | 280744 | 236453 | 233703 | 2750 | 23645 | 25949 | -2304 | 4.00 | 4.00 | 4.00 |
| MEDREG | REGISTRARS | 0 | 0 | 7095 | -7095 | 0 | 0 | 0 | 0.00 | 0.17 | 0.00 |
| MEDSHO | SENIOR HOUSE OFFICER | 295535 | 227337 | 213345 | 13992 | 22734 | 20935 | 1799 | 8.00 | 7.26 | 8.00 |
| MEDSPR | SPECIALIST REGISTRAR | 119746 | 108374 | 79669 | 28705 | 10837 | 8930 | 1907 | 3.00 | 1.98 | 2.00 |
| NURSEACY | AGENCY/BANK NURSING | 0 | 0 | 138385 | -138385 | 0 | 5942 | -5942 | 0.00 | 0.00 | 0.00 |
| WA&CAGCY | AGENCY ADMIN | 0 | 0 | 1802 | -1802 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| TOTAL SALARIES AND WAGES | | 3303556 | 2747359 | 2630516 | 116843 | 272885 | 270874 | 2011 | 131.91 | 111.87 | 120.66 |
| SUPPLIES | TOTAL SUPPLIES AND SERVICES | | | | | | | | | | |
| 0061 | MAINTENANCE INTERNAL | 192 | 160 | 0 | 160 | 16 | 0 | 16 | 0.00 | 0.00 | 0.00 |
| 0085 | TAXIS RECHARGE EXPENS | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| CLEAN | CLEANING SERVICES | 170 | 142 | 394 | -252 | 14 | 34 | -20 | 0.00 | 0.00 | 0.00 |
| DRESS | DRESSINGS | 5044 | 4203 | 3777 | 426 | 420 | 316 | 104 | 0.00 | 0.00 | 0.00 |
| DRUGS | DRUGS | 126417 | 105348 | 116186 | -10838 | 10535 | 14321 | -3786 | 0.00 | 0.00 | 0.00 |
| EQUIPPUR | EQUIPMENT PURCHASES | 2647 | 2206 | 174 | 2031 | 221 | 0 | 221 | 0.00 | 0.00 | 0.00 |
| EQUIPREP | REPAIR OF EQUIPMENT | 8019 | 6683 | 97 | 6586 | 668 | 0 | 668 | 0.00 | 0.00 | 0.00 |
| FOOD | PROVISIONS | 1179 | 983 | 40 | 943 | 98 | 0 | 98 | 0.00 | 0.00 | 0.00 |
| FURNPUR | FURNITURE PURCHASES | 0 | 0 | 3675 | -3675 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |

Parameter Set Name A1 Period 10/1999

Cost Centre : WOMAN
Cost Centre : NEONAT

| Account | | Annual Budget | YTD Budget | YTD Actuals | YTD Variance | Period Budget | Period Actuals | Period Variance | Estab-lishment | YTD WTE | Curr WTE |
|---|---|---|---|---|---|---|---|---|---|---|---|
| FURNREP | FURNITURE RENTALS AND | 0 | 0 | 1776 | -1776 | 0 | 16 | -16 | 0.00 | 0.00 | 0.00 |
| GENSERV | NON MEDICAL DISPOSABL | 2953 | 2461 | 2983 | -522 | 246 | 263 | -17 | 0.00 | 0.00 | 0.00 |
| INCOP | INCONTINENCE PRODUCTS | 0 | 0 | 3881 | -3881 | 0 | 1 | -1 | 0.00 | 0.00 | 0.00 |
| INST | INSTRUMENTS AND SUNDR | 152237 | 126864 | 192910 | -66046 | 12686 | 16019 | -3332 | 0.00 | 0.00 | 0.00 |
| LABS | LABS | 5102 | 4252 | 2197 | 2055 | 425 | 436 | -11 | 0.00 | 0.00 | 0.00 |
| LAUNDRY | LAUNDRY EXPENSES | 6725 | 5604 | 3072 | 2532 | 560 | -29 | 590 | 0.00 | 0.00 | 0.00 |
| MISCEXP | MISCELLANEOUS EXPENSE | 2758 | 2299 | 13317 | -11018 | 230 | 749 | -520 | 0.00 | 0.00 | 0.00 |
| PAPER | STATIONERY | 1021 | 851 | 7277 | -6426 | 85 | 414 | -329 | 0.00 | 0.00 | 0.00 |
| PARA-SUP | PARAMEDICAL SUPPLIES | 5006 | 4172 | 2543 | 1629 | 417 | 705 | -288 | 0.00 | 0.00 | 0.00 |
| PHONES | STATIONERY AND PHONES | 96 | 80 | 396 | -316 | 8 | 40 | -32 | 0.00 | 0.00 | 0.00 |
| POST | POSTAGE & CARRIAGE | 0 | 0 | 1776 | -1776 | 0 | 192 | -192 | 0.00 | 0.00 | 0.00 |
| PROFFEES | PROFESSIONAL FEES | 0 | 0 | 1056 | -1056 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| R0099 | RECHARGEABLE EXPENDIT | 0 | 0 | 122 | -122 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| RECRUIT | RECRUITMENT ADVERTISI | 0 | 0 | 4135 | -4135 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| STAFFOTH | OTHER STAFF EXPENDITU | 0 | 0 | 543 | -543 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| SURGAPP | SURGAPP | 884 | 737 | 0 | 737 | 74 | 0 | 74 | 0.00 | 0.00 | 0.00 |
| TRANS | TRANSPORT | 2005 | 1671 | 26 | 1644 | 167 | 0 | 167 | 0.00 | 0.00 | 0.00 |
| TRAVEL | TRAVEL AND SUBSISTENC | 942 | 785 | 1881 | -1096 | 79 | 123 | -45 | 0.00 | 0.00 | 0.00 |
| UNIFORMS | UNIFORMS | 96 | 80 | 174 | -94 | 8 | 17 | -9 | 0.00 | 0.00 | 0.00 |
| XOM | EXTRAORDINARY MAINTEN | 0 | 0 | 991 | -991 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| TOTAL SUPPLIES AND SERVICES | | 323494 | 269579 | 365398 | -95819 | 26958 | 33618 | -6660 | 0.00 | 0.00 | 0.00 |
| TOTAL EXPENSE | | 3627050 | 3016938 | 2995914 | 21024 | 299843 | 304492 | -4649 | 131.91 | 111.87 | 120.66 |
| TOTINC | TOTAL INCOME | | | | | | | | | | |
| TOTINC | TOTAL INCOME | | | | | | | | | | |
| 0854 | H+C REFERRALS-OTH SHS | -7125 | -5938 | 0 | -5938 | -594 | 0 | -594 | 0.00 | 0.00 | 0.00 |
| TOTAL INCOME | | -7125 | -5938 | 0 | -5938 | -594 | 0 | -594 | 0.00 | 0.00 | 0.00 |
| TOTAL INCOME | | -7125 | -5938 | 0 | -5938 | -594 | 0 | -594 | 0.00 | 0.00 | 0.00 |

Parameter Set Name A1 Period 10/1999

Cost Centre : WOMAN
Cost Centre : NEONAT

| Account | Annual Budget | YTD Budget | YTD Actuals | YTD Variance | Period Budget | Period Actuals | Period Variance | Estab-lishment | YTD WTE | Curr WTE |
|---|---|---|---|---|---|---|---|---|---|---|
| NEONAT | 3619925 | 3011000 | 2995914 | 15086 | 299249 | 304492 | -5243 | 131.91 | 111.87 | 120.66 |

Parameter Set Name A1 Period 10/1999

Cost Centre : WOMAN
Cost Centre : OBSTRC

| Account | | Annual Budget | YTD Budget | YTD Actuals | YTD Variance | Period Budget | Period Actuals | Period Variance | Establishment | YTD WTE | Curr WTE |
|---|---|---|---|---|---|---|---|---|---|---|---|
| TOTEXP | TOTAL EXPENSE | | | | | | | | | | |
| SALARIES | TOTAL SALARIES AND WAGES | | | | | | | | | | |
| 7113 | NURSE CLIN. SCALE I | 92569 | 77141 | 76827 | 315 | 7714 | 5151 | 2563 | 3.00 | 3.00 | 2.00 |
| 7114 | NURSE CLIN. SCALE H | 57438 | 47865 | 49225 | -1360 | 4787 | 5037 | -251 | 2.00 | 2.00 | 2.00 |
| 7115 | NURSE CLIN. SCALE G | 573288 | 479566 | 1091914 | -612348 | 47107 | 109450 | -62343 | 19.58 | 45.88 | 46.06 |
| 7116 | NURSE CLIN. SCALE F | 2713136 | 2261688 | 1557728 | 703960 | 228760 | 156503 | 72257 | 104.12 | 71.94 | 70.88 |
| 7117 | NURSE CLIN. SCALE E | 1952625 | 1622584 | 1614304 | 8280 | 165020 | 164553 | 468 | 89.36 | 88.16 | 88.36 |
| 7119 | NURSE CLIN. SCALE C | 10944 | 9120 | 9117 | 2 | -2124 | 912 | -3036 | 0.73 | 0.73 | 0.73 |
| 7199 | NURSING REGISTERED OT | 0 | 0 | -19306 | 19306 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| 7311 | NURSING AUXILIARY-A | 706845 | 587889 | 466308 | 121581 | 59684 | 42433 | 17251 | 53.94 | 41.93 | 38.33 |
| 7315 | NURSERY NURSE - B | 261570 | 218760 | 216298 | 2461 | 20536 | 22050 | -1513 | 14.27 | 14.32 | 14.80 |
| 7350 | SUPPORT WORKER | 0 | 0 | 100028 | -100028 | 0 | 14071 | -14071 | 0.00 | 9.28 | 13.00 |
| 7757 | A & C GRADE 4 | 6924 | 5770 | 5579 | 191 | 577 | 557 | 20 | 0.44 | 0.43 | 0.43 |
| 7758 | A & C GRADE 3 | 5057 | 4214 | 2815 | 1399 | 421 | 144 | 277 | 0.47 | 0.29 | 0.15 |
| 7759 | A & C GRADE 2 | 101542 | 84619 | 84815 | -196 | 8879 | 7747 | 1132 | 9.60 | 9.50 | 8.59 |
| 7775 | SENIOR MANAGER 5 | 0 | 0 | 3427 | -3427 | 0 | 3427 | -3427 | 0.00 | 0.10 | 1.00 |
| 8199 | OTHER MISCELLANEOUS P | 0 | 0 | 3647 | -3647 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| NURSEACY | AGENCY/BANK NURSING | 0 | 0 | 165703 | -165703 | 0 | 13977 | -13977 | 0.00 | 0.00 | 0.00 |
| TOTAL SALARIES AND WAGES | | 6481939 | 5399216 | 5428431 | -29215 | 541362 | 546012 | -4650 | 297.51 | 287.56 | 286.33 |
| SUPPLIES | TOTAL SUPPLIES AND SERVICES | | | | | | | | | | |
| CLEAN | CLEANING SERVICES | 615 | 513 | 1010 | -497 | 51 | 210 | -159 | 0.00 | 0.00 | 0.00 |
| CONTRACT | CONTRACTS | 362 | 302 | 0 | 302 | 30 | 0 | 30 | 0.00 | 0.00 | 0.00 |
| DRESS | DRESSINGS | 84521 | 70434 | 60994 | 9440 | 7043 | 3407 | 3637 | 0.00 | 0.00 | 0.00 |
| DRUGS | DRUGS | 177101 | 147584 | 153629 | -6045 | 14758 | 13113 | 1645 | 0.00 | 0.00 | 0.00 |
| EQUIPPUR | EQUIPMENT PURCHASES | 3015 | 2513 | 167 | 2345 | 1192 | -24 | 1215 | 0.00 | 0.00 | 0.00 |
| FOOD | PROVISIONS | 257 | 215 | 290 | -76 | 21 | 0 | 21 | 0.00 | 0.00 | 0.00 |
| FURNPUR | FURNITURE PURCHASES | 80 | 66 | 3042 | -2975 | -934 | 0 | -934 | 0.00 | 0.00 | 0.00 |
| FURNREP | FURNITURE RENTALS AND | 0 | 0 | 134 | -134 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| GENSERV | NON MEDICAL DISPOSABL | 9327 | 7772 | 3397 | 4375 | 777 | 162 | 615 | 0.00 | 0.00 | 0.00 |
| INCOP | INCONTINENCE PRODUCTS | 0 | 0 | 12490 | -12490 | 0 | 2803 | -2803 | 0.00 | 0.00 | 0.00 |
| INRECHGE | INTERNAL RECHARGES | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| INST | INSTRUMENTS AND SUNDR | 174314 | 145261 | 173757 | -28495 | 14526 | 11952 | 2574 | 0.00 | 0.00 | 0.00 |
| LABS | LABS | 198450 | 165375 | 154035 | 11340 | 16537 | 19829 | -3291 | 0.00 | 0.00 | 0.00 |
| LAUNDRY | LAUNDRY EXPENSES | 27478 | 22898 | 5150 | 17748 | 2290 | 313 | 1977 | 0.00 | 0.00 | 0.00 |
| LOSSDAM | LOSS / THEFT / DAMAGE | 0 | 0 | 63 | -63 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| MAINTAIN | PROPERTY MAINTENANCE | 0 | 0 | 547 | -547 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| MISCEXP | MISCELLANEOUS EXPENSE | 14207 | 11839 | 11861 | -22 | 1184 | 671 | 513 | 0.00 | 0.00 | 0.00 |

Parameter Set Name A1 Period 10/1999

Cost Centre : WOMAN
Cost Centre : OBSTRC

| Account | | Annual Budget | YTD Budget | YTD Actuals | YTD Variance | Period Budget | Period Actuals | Period Variance | Estab-lishment | YTD WTE | Curr WTE |
|---|---|---|---|---|---|---|---|---|---|---|---|
| OTHORG | OTHER EXTERNAL ORGANI | 0 | 0 | 421 | -421 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| PAPER | STATIONERY | 7203 | 6002 | 12956 | -6954 | 600 | 644 | -44 | 0.00 | 0.00 | 0.00 |
| PARA-SUP | PARAMEDICAL SUPPLIES | 12598 | 10498 | 7410 | 3088 | 1050 | 978 | 72 | 0.00 | 0.00 | 0.00 |
| PHONES | STATIONERY AND PHONES | 2500 | 2083 | 6249 | -4166 | 208 | 791 | -583 | 0.00 | 0.00 | 0.00 |
| POST | POSTAGE & CARRIAGE | 4512 | 3760 | 2264 | 1496 | 376 | 375 | 1 | 0.00 | 0.00 | 0.00 |
| PROFFEES | PROFESSIONAL FEES | 48115 | 40096 | 52126 | -12030 | 4010 | 4523 | -513 | 0.00 | 0.00 | 0.00 |
| RECRUIT | RECRUITMENT ADVERTISI | 0 | 0 | 641 | -641 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| SURGAPP | SURGAPP | 2342 | 1952 | 2422 | -470 | 195 | 106 | 89 | 0.00 | 0.00 | 0.00 |
| TRANS | TRANSPORT | 0 | 0 | 8816 | -8816 | 0 | 1134 | -1134 | 0.00 | 0.00 | 0.00 |
| TRAVEL | TRAVEL AND SUBSISTENC | 136232 | 113527 | 62830 | 50697 | 11353 | 6843 | 4510 | 0.00 | 0.00 | 0.00 |
| UNIFORMS | UNIFORMS | 3813 | 3178 | 3939 | -761 | 318 | 253 | 65 | 0.00 | 0.00 | 0.00 |
| XOM | EXTRAORDINARY MAINTEN | 0 | 0 | 1896 | -1896 | 0 | 930 | -930 | 0.00 | 0.00 | 0.00 |
| TOTAL SUPPLIES AND SERVICES | | 907041 | 755868 | 742535 | 13333 | 75587 | 69015 | 6572 | 0.00 | 0.00 | 0.00 |
| TOTAL EXPENSE | | 7388980 | 6155084 | 6170966 | -15882 | 616948 | 615026 | 1922 | 297.51 | 287.56 | 286.33 |
| TOTINC | TOTAL INCOME | | | | | | | | | | |
| TOTINC | TOTAL INCOME | | | | | | | | | | |
| 0980 | OTHER MISCELLANEOUS I | 0 | 0 | -4294 | 4294 | 0 | -200 | 200 | 0.00 | 0.00 | 0.00 |
| TOTAL INCOME | | 0 | 0 | -4294 | 4294 | 0 | -200 | 200 | 0.00 | 0.00 | 0.00 |
| TOTAL INCOME | | 0 | 0 | -4294 | 4294 | 0 | -200 | 200 | 0.00 | 0.00 | 0.00 |
| OBSTRC | | 7388980 | 6155084 | 6166672 | -11588 | 616948 | 614826 | 2122 | 297.51 | 287.56 | 286.33 |

Parameter Set Name A1 Period 10/1999

Cost Centre : WOMAN
Cost Centre : REPRO

| Account | | Annual Budget | YTD Budget | YTD Actuals | YTD Variance | Period Budget | Period Actuals | Period Variance | Estab-lishment | YTD WTE | Curr WTE |
|---|---|---|---|---|---|---|---|---|---|---|---|
| TOTEXP | TOTAL EXPENSE | | | | | | | | | | |
| SALARIES | TOTAL SALARIES AND WAGES | | | | | | | | | | |
| 4874 | LOCUM - SENIOR HOUSE | 0 | 0 | 2132 | -2132 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| 5202 | PAYMNTS TO OTHHOSP RE | -7004 | -5836 | -5836 | 0 | -584 | -583 | -1 | 0.00 | 0.00 | 0.00 |
| 7025 | PRACTITIONER-PART II | 0 | 0 | 11636 | -11636 | 0 | 1610 | -1610 | 0.00 | 0.31 | 0.45 |
| 7052 | ASSOCIATE SPECLST/STA | 35028 | 32475 | 28367 | 4108 | 2481 | 2919 | -438 | 0.55 | 0.53 | 0.64 |
| 7055 | DOMICILIARY VISITS & | 0 | 138 | 0 | 138 | 14 | 0 | 14 | 0.00 | 0.00 | 0.00 |
| 7056 | FAMILY PLANNING FEES | 114639 | 110160 | 88556 | 21604 | 5552 | 4419 | 1133 | 0.00 | 0.00 | 0.00 |
| 7113 | NURSE CLIN. SCALE I | 31742 | 26452 | 26614 | -162 | 2645 | 2639 | 6 | 1.00 | 1.00 | 1.00 |
| 7114 | NURSE CLIN. SCALE H | 0 | 0 | 4748 | -4748 | 0 | 475 | -475 | 0.00 | 0.20 | 0.20 |
| 7115 | NURSE CLIN. SCALE G | 42002 | 35366 | 37087 | -1721 | 3318 | 3706 | -388 | 1.52 | 1.67 | 1.53 |
| 7116 | NURSE CLIN, SCALE F | 17405 | 14504 | 12304 | 2200 | 1450 | 1230 | 220 | 0.74 | 0.64 | 0.64 |
| 7117 | NURSE CLIN. SCALE E | 13884 | 11570 | 8845 | 2725 | 1157 | 989 | 168 | 0.75 | 0.50 | 0.50 |
| 7199 | NURSING REGISTERED OT | 11301 | 9418 | 9418 | 0 | 942 | 942 | 0 | 0.00 | 0.00 | 0.00 |
| 7311 | NURSING AUXILIARY-A | 0 | 0 | 6007 | -6007 | 0 | 615 | -615 | 0.00 | 0.67 | 0.67 |
| 7402 | CLIN. SCIENTIST - B | 31338 | 26115 | 28426 | -2311 | 2612 | 2842 | -231 | 1.00 | 1.00 | 1.00 |
| 7517 | M L S O - 1 | 17959 | 14966 | 16238 | -1272 | 1497 | 1618 | -121 | 1.00 | 1.00 | 1.00 |
| 7518 | M L A | 9550 | 7958 | 8917 | -958 | 796 | 892 | -96 | 1.00 | 1.00 | 1.00 |
| 7756 | A & C GRADE 5 | 37953 | 31628 | 31865 | -238 | 3163 | 3148 | 14 | 2.00 | 2.00 | 2.00 |
| 7757 | A & C GRADE 4 | 33696 | 28080 | 23667 | 4412 | 2808 | 1213 | 1595 | 2.00 | 1.86 | 1.00 |
| 7758 | A & C GRADE 3 | 213953 | 179272 | 172063 | 7209 | 17266 | 14463 | 2803 | 15.45 | 16.01 | 13.94 |
| 7759 | A & C GRADE 2 | 114771 | 95364 | 94189 | 1175 | 9536 | 9522 | 14 | 10.24 | 10.09 | 9.78 |
| 7775 | SENIOR MANAGER 5 | 38610 | 32175 | 32364 | -189 | 3218 | 3236 | -19 | 1.00 | 1.00 | 1.00 |
| 7777 | SENIOR MANAGER 7 | 27406 | 22839 | 25789 | -2950 | 2284 | 2564 | -280 | 0.50 | 0.50 | 0.50 |
| 8099 | OTHER TRADESMEN | 4797 | 3997 | 0 | 3997 | 400 | 0 | 400 | 0.00 | 0.00 | 0.00 |
| MEDAGCY | AGENCY JUNIOR MEDICAL | 0 | 10225 | 8736 | 1489 | 1023 | 1905 | -883 | 0.00 | 0.25 | 0.79 |
| MEDCON | CONSULTANTS | 846617 | 689229 | 709970 | -20741 | 65550 | 72124 | -6575 | 9.64 | 9.64 | 9.66 |
| MEDREG | REGISTRARS | 0 | 0 | 15244 | -15244 | 0 | 4009 | -4009 | 0.00 | 0.35 | 1.05 |
| MEDSHO | SENIOR HOUSE OFFICER | 605238 | 543707 | 482434 | 61273 | 54371 | 47001 | 7369 | 17.50 | 16.93 | 16.00 |
| MEDSPR | SPECIALIST REGISTRAR | 721306 | 564425 | 558195 | 6230 | 56442 | 51860 | 4582 | 15.00 | 14.11 | 13.06 |
| NURSEACY | AGENCY/BANK NURSING | 0 | 0 | -708 | 708 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| UNICON | UNIVERSITY CONSULTANT | 264113 | 213645 | 246926 | -33282 | 48176 | 41638 | 6538 | 0.00 | 0.00 | 0.00 |
| UNIOTH | OTHER UNIVERSITY STAF | 155799 | 129833 | 129833 | 0 | 12983 | 12984 | -1 | 0.00 | 0.00 | 0.00 |
| VACANCY | VACANCY | 0 | 0 | 0 | 0 | 17916 | 0 | 17916 | 0.00 | 0.00 | 0.00 |
| WA&CAGCY | AGENCY ADMIN | 0 | 0 | 14301 | -14301 | 0 | 1573 | -1573 | 0.00 | 0.00 | 0.00 |
| TOTAL SALARIES AND WAGES | | 3382104 | 2827703 | 2828329 | -626 | 317015 | 291556 | 25459 | 80.89 | 81.25 | 77.41 |
| SUPPLIES | TOTAL SUPPLIES AND SERVICES | | | | | | | | | | |

Parameter Set Name A1 Period 10/1999

Cost Centre : WOMAN
Cost Centre : REPRO

| Account | | Annual Budget | YTD Budget | YTD Actuals | YTD Variance | Period Budget | Period Actuals | Period Variance | Estab-lishment | YTD WTE | Curr WTE |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 0051 | STEAM INTERNAL RECHAR | 10790 | 8992 | 8990 | 2 | 899 | 899 | 0 | 0.00 | 0.00 | 0.00 |
| 0056 | ELECTCITY INTERNAL RE | 43102 | 35919 | 29637 | 6281 | 3592 | 2549 | 1043 | 0.00 | 0.00 | 0.00 |
| 0061 | MAINTENANCE INTERNAL | 1190 | 992 | 0 | 992 | 99 | 0 | 99 | 0.00 | 0.00 | 0.00 |
| 0085 | TAXIS RECHARGE EXPENS | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| 0088 | COURIER INTERNAL RECH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| 0202 | CAPITAL ALLOC FOR SUP | 0 | 0 | 88 | -88 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| CLEAN | CLEANING SERVICES | 29898 | 24915 | 24920 | -5 | 2491 | 2492 | -1 | 0.00 | 0.00 | 0.00 |
| DRESS | DRESSINGS | 0 | 0 | 43 | -43 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| DRUGS | DRUGS | 0 | 0 | 125 | -125 | 0 | 7 | -7 | 0.00 | 0.00 | 0.00 |
| EQUIPPUR | EQUIPMENT PURCHASES | 0 | 0 | 323 | -323 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| EQUIPREN | RENT OF EQUIPMENT | 2118 | 1765 | 782 | 983 | 177 | 61 | 116 | 0.00 | 0.00 | 0.00 |
| EQUIPREP | REPAIR OF EQUIPMENT | 4 | 3 | 0 | 3 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| FOOD | PROVISIONS | 0 | 0 | 3272 | -3272 | 0 | 263 | -263 | 0.00 | 0.00 | 0.00 |
| FURNPUR | FURNITURE PURCHASES | 5595 | 4663 | 2116 | 2547 | 466 | 0 | 466 | 0.00 | 0.00 | 0.00 |
| FURNREP | FURNITURE RENTALS AND | 4511 | 3759 | 2589 | 1170 | 376 | 89 | 287 | 0.00 | 0.00 | 0.00 |
| GENSERV | NON MEDICAL DISPOSABL | 22222 | 18518 | 12789 | 5730 | 1852 | 3145 | -1293 | 0.00 | 0.00 | 0.00 |
| INST | INSTRUMENTS AND SUNDR | 0 | 0 | 514 | -514 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| LABS | LABS | 0 | 0 | 320 | -320 | 0 | 32 | -32 | 0.00 | 0.00 | 0.00 |
| LAUNDRY | LAUNDRY EXPENSES | 2009 | 1674 | 0 | 1674 | 167 | 0 | 167 | 0.00 | 0.00 | 0.00 |
| MAINTAIN | PROPERTY MAINTENANCE | 10019 | 8349 | 1736 | 6613 | 835 | 7 | 828 | 0.00 | 0.00 | 0.00 |
| MISCEXP | MISCELLANEOUS EXPENSE | 0 | 0 | -1128 | 1128 | -7554 | 0 | -7554 | 0.00 | 0.00 | 0.00 |
| OTHORG | OTHER EXTERNAL ORGANI | 97798 | 81498 | 81467 | 31 | 8150 | 8119 | 31 | 0.00 | 0.00 | 0.00 |
| PAPER | STATIONERY | 4370 | 3642 | 21523 | -17882 | 364 | 171 | 193 | 0.00 | 0.00 | 0.00 |
| PARA-SUP | PARAMEDICAL SUPPLIES | 0 | 0 | 180 | -180 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| PHONES | STATIONERY AND PHONES | 0 | 0 | 12713 | -12713 | 0 | 976 | -976 | 0.00 | 0.00 | 0.00 |
| POST | POSTAGE & CARRIAGE | 18269 | 15225 | 75 | 15150 | 1522 | 3 | 1519 | 0.00 | 0.00 | 0.00 |
| PROFFEES | PROFESSIONAL FEES | 0 | 0 | 75 | -75 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| RATES | RATES | 0 | 0 | 1990 | -1990 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| RECRUIT | RECRUITMENT ADVERTISI | 1001 | 835 | 1613 | -778 | 83 | 126 | -43 | 0.00 | 0.00 | 0.00 |
| STAFFOTH | OTHER STAFF EXPENDITU | 0 | 0 | 505 | -505 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| TRAINING | TRAINING | 19310 | 16092 | 19232 | -3141 | 1609 | 1486 | 123 | 0.00 | 0.00 | 0.00 |
| TRANS | TRANSPORT | 0 | 0 | 980 | -980 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| TRAVEL | TRAVEL AND SUBSISTENC | 23506 | 19589 | 14883 | 4705 | 1959 | 308 | 1651 | 0.00 | 0.00 | 0.00 |
| UNIFORMS | UNIFORMS | 0 | 0 | 80 | -80 | 0 | 3 | -3 | 0.00 | 0.00 | 0.00 |
| XOM | EXTRAORDINARY MAINTEN | 4068 | 3390 | 6796 | -3406 | 339 | 1010 | -671 | 0.00 | 0.00 | 0.00 |
| TOTAL SUPPLIES AND SERVICES | | 299780 | 249817 | 249228 | 589 | 17428 | 21746 | -4318 | 0.00 | 0.00 | 0.00 |
| TOOTHCAT | TOTAL OTHER CATEGORIES | | | | | | | | | | |
| 6000 | CRES (5340;5351;5352) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |

Parameter Set Name A1 Period 10/1999

Cost Centre : WOMAN
Cost Centre : REPRO

| Account | | Annual Budget | YTD Budget | YTD Actuals | YTD Variance | Period Budget | Period Actuals | Period Variance | Estab-lishment | YTD WTE | Curr WTE |
|---|---|---|---|---|---|---|---|---|---|---|---|
| TOTAL OTHER CATEGORIES | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| TOTAL EXPENSE | | 3681885 | 3077520 | 3077557 | -37 | 334443 | 313301 | 21142 | 80.89 | 81.25 | 77.41 |
| TOTINC | TOTAL INCOME | | | | | | | | | | |
| TOTINC | TOTAL INCOME | | | | | | | | | | |
| 0839 | AMENITY BED PATIENTS | -52000 | -43333 | -18363 | -24970 | -4333 | 10711 | -15044 | 0.00 | 0.00 | 0.00 |
| 0910 | LABORATORY FEES | -15500 | -12917 | -12057 | -860 | -1292 | -1000 | -292 | 0.00 | 0.00 | 0.00 |
| 0912 | OTHER FEES | 0 | 0 | -129 | 129 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| 0925 | RECHARGES TO UNIVERSI | -94715 | -78929 | -78929 | 0 | -7893 | -7893 | 0 | 0.00 | 0.00 | 0.00 |
| 0931 | TRAINING GRADE INCOME | 0 | -56427 | -44518 | -11909 | -5643 | 4857 | -10500 | 0.00 | 0.00 | 0.00 |
| 0965 | ME SUBSIDIES (NOT ACT | 0 | 0 | 0 | 0 | 11011 | 0 | 11011 | 0.00 | 0.00 | 0.00 |
| 0980 | OTHER MISCELLANEOUS I | -73015 | -60846 | -63713 | 2867 | -9402 | -5999 | -3403 | 0.00 | 0.00 | 0.00 |
| L0864 | PRIVATE IP | -7285 | -6071 | -2744 | -3327 | -6071 | -2744 | -3327 | 0.00 | 0.00 | 0.00 |
| L0867 | PRIVATE - AMENITY BED | 0 | 0 | -13454 | 13454 | 0 | -12479 | 12479 | 0.00 | 0.00 | 0.00 |
| L0961 | POST GRADUATE INCOME- | 0 | 0 | -11577 | 11577 | 0 | -9967 | 9967 | 0.00 | 0.00 | 0.00 |
| L0965 | AIDS INCOME | -14681 | -12234 | -12230 | -4 | -12234 | -1223 | -11011 | 0.00 | 0.00 | 0.00 |
| OSEAS | INCOME FROM NON-EC PA | 0 | 0 | -1438 | 1438 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| R0840 | PRIVATE INPATIENTS | -10000 | -8333 | -10187 | 1854 | -833 | 0 | -833 | 0.00 | 0.00 | 0.00 |
| R0842 | PRIVATE DAY CASES | 0 | 0 | -1368 | 1368 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| R0900 | LABORATORY IN | -47164 | -47164 | -47164 | 0 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| TOTAL INCOME | | -314360 | -326255 | -317871 | -8384 | -36691 | -25737 | -10953 | 0.00 | 0.00 | 0.00 |
| TOTAL INCOME | | -314360 | -326255 | -317871 | -8384 | -36691 | -25737 | -10953 | 0.00 | 0.00 | 0.00 |
| REPRO | | 3367524 | 2751266 | 2759686 | -8420 | 297752 | 287564 | 10188 | 80.89 | 81.25 | 77.41 |