Social Science & Medicine 82 (2013) 147–155

Contents lists available at SciVerse ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

McDonaldization or Commercial Re-stratification: Corporatization and the multimodal organisation of English doctors

Justin Waring*, Simon Bishop

Nottingham University Business School, University of Nottingham, United Kingdom

ARTICLE INFO

Article history:
Available online 28 December 2012

Keywords:
United Kingdom
Medical profession
Restratification
Commercialisation
Bureaucracy
Private healthcare

ABSTRACT

This paper investigates transitions in the social organisation of medicine found in the extended opportunities for private corporations to own, manage and deliver public healthcare services in the English National Health Service. It follows recent calls to explain the reconstruction of medical work without reducing analysis to either the structures of organisational control or the strategic resistance of doctors. Accordingly, the paper considers how doctors interact, mediate and co-create new organisational environments. Central to our analysis are the variable sources of power that influence whether doctors acquiesce, resist or re-create change. Drawing on ethnographic research carried out between 2006 and 2010 in two Independent Sector Treatment Centres – private providers of public healthcare - the paper shows how doctors' responses to bureaucratic and commercial structures reflect their own structured forms of power, which have variable value within this new commercial environment. These include clinical experience and specialist knowledge, but also social and economic influence. Building on established sociological debates, these divergent sources of power explain how for some doctors the expansion of private healthcare might involve more extreme forms of *McDonaldization*, while for others it might involve opportunities for *Commercial Re-stratification*.

© 2013 Elsevier Ltd. All rights reserved.

Introduction

Governments across the developed world continue to look for more economical ways of producing healthcare (OECD, 2011). For many countries, mixed markets of public, private and third sector providers are again favoured for reducing the bureaucracy, inefficiencies and lack of patient choice often associated with universal public sector provision (Kaplan & Porter, 2011; Ovretveit, 1996). The extended opportunities for businesses to manage public healthcare resurface longstanding sociological debates on the social organisation of medicine (Timmermans & Oh, 2010). The corporatisation of healthcare, especially in the United States, is typically interpreted as ending the 'golden age' of medicine (McKinlay & Marceau, 2002; Scott, Ruef, Mendel, & Caronna, 2000). For countries currently looking to extend the mixed economy of care, such as the English National Health Service (NHS), it is important to re-engage with these debates.

Research on the social organisation of medicine reveals a complex and contingent picture of change. Although managerial and corporate interests appear to have limited medical decision-making, standardised practices and introduced more explicit forms of governance, these have not been experienced equally (Casalino, 2004). Research tends to present the social re-organisation of medicine in one of two ways (Numerato, Salvatore, & Fattore, 2012). The first shows institutional change as challenging the autonomy and power of medicine (e.g. Light, 1995; McKinlay & Stoeckle, 1988; Scott et al., 2000). The second shows doctors as actively resisting, adapting to or capturing reforms to advance their interests (e.g. Freidson, 1985; Waring & Currie, 2009). Doctors are therefore presented as either 'de-professionalised victims' or 'strategic operators' (Gleeson & Knights, 2006). Yet, each perspective potentially over-states or reduces analysis to one set of factors without examining the relationship between the two. As such, our paper follows recent calls to investigate how structural change interacts with and is co-created by the agency of professionals (Gleeson & Knights, 2006; Numerato et al., 2012). In particular, we suggest doctors' ability to acquiesce, resist or recreate change is itself contingent upon the variable sources of influence or power that frame their ability to act. The acquisition and control of specialist knowledge or moral codes are often highlighted as providing the basis of professionalisation or social closure (e.g. Brint, 1994; Freidson, 1970), but we also recognise power derived from other social and economic resources, which are increasingly valuable in the context of commercialisation.

* Corresponding author.
E-mail addresses: Justin.waring@nottingham.ac.uk, jj_waring@hotmail.com (J. Waring), simon.bishop@nottingham.ac.uk (S. Bishop).

0277-9536/$ – see front matter © 2013 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.socscimed.2012.12.023

Our study is located within the English NHS, where policies have re-introduced the type of managed-markets experienced in the 1990s (DH, 2010). In particular, reforms require locality groups of family doctors to commission specialist services from a 'liberated' market of 'qualified' providers (DH, 2010). This builds on patterns of service diversification introduced under previous governments where private businesses acquired a larger role in service delivery (DH, 2000). The introduction of Independent Sector Treatment Centres (ISTCs) in the mid-2000s exemplifies this trend. Owned and operated by private companies, ISTCs aim to expand NHS capacity, reduce waiting times and increase patient choice (DH, 2005). However, research suggests that in seeking to achieve these goals, ISTCs might extend commercial interests and managerial controls over medical work (Gabbay et al., 2011; Turner, Allen, Bartlett, & Pérotin, 2011). As an example of more commercial service models, ISTCs therefore provide an illustrative case for the future organisation of English medicine and an empirical site for re-assessing sociological research on the commercialisation of medicine.

Beyond the dualism of hegemony or resistance

Although the medical profession retains significant influence within policy-making, service organisation and care delivery, it also seems the logics of the market and bureaucracy have replaced professionalism in the organisation of expert work (Freidson, 2001; Scott et al., 2000). Reflecting this, three linked theoretical debates frame the contemporary organisation of medicine.

The first relates to the longstanding ambitions of policy-makers, funders and corporations to better rationalise healthcare services, especially in regards to the financial and clinical consequences of medical autonomy. This *bureaucratisation* has evolved in two ways. The first is associated with vertical structures of hierarchical control through the 'rationalising' and 'countervailing' interests of management and extensive use of governance technologies in relation to resource allocation, service planning and quality control (Alford, 1977; Flynn, 1992; Harrison & Ahmad, 2000; Light, 1995; Waring, Dixon-Woods, & Yeung, 2010). In the English NHS, for example, the introduction of General Management in the mid-1980s established new managerial prerogatives for decision-making, budgeting and performance management that appeared to challenge medical authority (Harrison & Ahmad, 2000). The second is associated with horizontal structures of control found in the standardisation and reconfiguration of clinical practices through formulaic, evidence-based care processes (Harrison, 2002; McDonald & Harrison, 2004; Ritzer & Walcak, 1988; Timmermans & Berg, 2003). This is often linked to corporate or government demands for more standardised and predictable care, together with concerns about sub-standard quality, which have led to a form of 'assembly-line' medicine (Harrison, 2002; McKinlay & Stoeckle, 1988). These examples of bureaucratisation reflect wider political, economic and ideological imperatives for more accountable, economical and rational healthcare that are evident in both public and private healthcare services, and broadly reflect the McDonaldization of healthcare (Rizter, 1996).

The second theme relates to the growing influence of corporate interest in healthcare. The *commercialisation* of medicine is prominent, for example, in Starr's (1982) analysis of US medicine where he saw the failure of public bodies to rationalise medical work as leading to rationalisation via market and corporate structures. This included a shift to 'for-profit' provision, doctors working as salaried employees, the re-configuration of services into larger entities, and the concentration of ownership within corporate conglomerates. For healthcare systems like the US, corporatisation is particularly advanced, where insurance funds and corporate hospitals determine remuneration, patient selection and treatment options (McKinlay & Marceau, 2002; Scott et al., 2000). In healthcare systems with more public and universal provision, corporatisation is less developed, yet some features have emerged through the use of managed-markets to allocate resources, financial incentives to reward behaviours, private investment in care facilities and global business interests in regional policy-making, especially from the pharmaceutical industry (Mackintosh & Koivusalo, 2004; Timmermans & Oh, 2010). A further feature of commercialisation is the growth of consumer-like behaviours amongst patients that further undermine the authority of doctors, whether through government 'choice' policies, declining trust in the wake of scandals or increased access to health-related information (Harrison & Ahmad, 2000; Mechanic, 2008; Timmermans & Oh, 2010).

The third area of debate considers how these institutional trends are reflected at the intra-professional level (Freidson, 1985; Kirkpatrick et al., 2009). Freidson's (1985) *re-stratification* thesis highlights how professional 'elites' work within these bureaucratic and corporate structures to advance the collective interests of their 'rank-and-file' colleagues. This includes 'knowledge elites' in the creation of guidelines and 'administrative' elites who direct and monitor work processes. These professional strata buffer corporate or managerial interests and protect professional authority, albeit with some reduced autonomy for individual doctors (Freidson, 1985). Where others have indicated de-professionalisation in the context of institutional change (McKinlay & Stoeckle, 1988), re-stratification suggests a form of re-professionalisation. However, these 'hybrid' professional-managerial and clinical leadership positions might also co-opt doctors into bureaucratic hierarchies to serve corporate or political interests, especially in 'hard to reach' areas where managerial influence is limited (Coburn, Rappolt, & Bourgeault, 1997). Moreover, they often blur professional and managerial practices, cultures and ideologies leading to new and precarious occupational forms (Noordegraaf, 2007; Waring & Currie, 2009).

Through these debates, the re-construction of professional work is typically presented in one of two ways (Gleeson & Knights, 2006). On the one hand, research shows corporate or government structures as eroding clinical autonomy, transforming professional identities and creating the possibilities for de-professionalisation (e.g. McKinlay & Stoeckle, 1988; Scott et al., 2000). This involves a fundamental change in the nature of medical professionalism, as autonomous expert practices, shared codes of conduct and collegial identities are replaced by corporate expectations for standardised work practices, external governance requirements and more enterprising cultures (Casalino, 2004; Evetts, 2003; White, 2004). On the other hand, doctors are portrayed as strategic agents who resist change to maintain their interests (Freidson, 1985). This highlights the ability of professionals to corrupt the intent of management, marginalise competitors and develop coalitions of resistance (Lozeau, Langley, & Denis, 2002; Nancarrow & Borthwick, 2005; Waring & Currie, 2009). Research suggests important variations in how doctors experience structural changes, for example, not all US doctors have been subject to direct corporate controls, e.g. as salaried employees (Casalino, 2004) and the role of doctors-in-management reflect international variations in the relationship between state and medicine (Kirkpatrick et al., 2009). In light of the above, there is a tendency to either under- or over-estimate the influence of the medical profession (Timmermans & Oh, 2010); and reduce analysis to either the structures of 'managerial hegemony' or the agency of 'medical resistance' (Numerato et al., 2012). Accordingly, studies call for greater attention to the interaction of structure and agency in the reconstruction of professional work (Gleeson & Knights, 2006; Numerato et al., 2012; Waring & Currie, 2009).

Download English Version:

https://daneshyari.com/en/article/952355

Download Persian Version:

https://daneshyari.com/article/952355

Daneshyari.com