Understanding power relationships within health care networks

Rachael Addicott
Senior Research Fellow
r.addicott@kingsfund.org.uk

The King’s Fund
Overview

› Context
› Networks and power
› Theories of power relationships
› Results: power relations within networks
› Bounded pluralism?
› Implications for policy

The King's Fund
Ideas that change health care
Context (up to 2005)

- 1997 – “Modernisation agenda”
- Cancer services
  - History of poor clinical outcomes
  - Ineffective communication between professionals and organisations
- Managed Clinical Networks (MCN) for Cancer
  “...linked groups of health professionals and organisations from primary, secondary and tertiary care working in a coordinated manner, unconstrained by existing professional and (organisational) boundaries to ensure equitable provision of high quality effective services” (Edwards, 2002: 63)
Networks and power

Assumption of cooperation in informal networks
- *Forced* relationships in MCNs?
- Government regulation and accountability
- Divergent stakeholders – competing purposes

Focus on generation of *shared* power
- What about power *within* networks?
Theories of power relationships

- **Pluralism (Dahl)**
  - Varied power relations
  - Focus on open conflict and decision-making
  - *Plural elite model*

- **Structuralism (Alford)**
  - Dominant groups control decision-making agenda
  - Structural interest groups

- **Post-structuralism (Fairclough)**
  - Link between power and specialist knowledge/discourse
  - Construction and maintenance of ideological assumptions
Methodology

› Comparative case studies of 5 London MCNs
  – Interviews (117)
  – Documentation
  – Observation (urology and gynaecology)

› Identification of power relations
  – Pluralism: cooperative bargaining between different coalitions of stakeholders over different issues
  – Structuralism: professional dominance in agenda setting
  – Post-structuralism: use of language to manipulate network activities
Results: Dominant Elites and Limited Local Control

- Two levels of power relations:
  - *Development* of policy and strategic direction
  - *Enactment* of this policy and strategic direction

- EG. Centralisation of specialist services
  - Requirement for centralisation by DOH / NICE
  - Configuration decision dominated by medical profession

- Role of network management team in dispute
  - No statutory influence
  - Power tended to default to medical profession
Results: Enactment of policy

- Medical dominance
  - Centres versus units
  - Conflicting roles
- Medical resistance
  - Configuration decision-making (presenting barriers)
  - Enactment (non-compliance)
Power Relations in the *Enactment* of Policy

- Medical professional internally divided
  - Dominant elites
  - Conflict over resource distribution
  - Division along organisational lines
- Limited control over agenda setting
- Combining managerial and clinical discourses
Networks and power: Bounded pluralism?

- Resources and power shared amongst a “bounded elite” of medical professionals from elite institutions
- Competition for scarce resources
- Coalitions of elites “joined forces” to override less dominant stakeholders
Conclusions and implications for policy

› Focus on enactment of policy *within* networks
› Reflects historical power relations

› *However...*

› Competitive environment which has damaged long-standing relationships
› Power was restricted by overriding accountability framework