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Pannon Management Review

Pannon Management Review contributes to bridging scholarly management research and management practitioner thinking worldwide. In particular, *Pannon Management Review* broadens the existing links between Hungarian scholars and practitioners, on the one hand, and the wider international academic and business communities, on the other—the journal acts as an overall Central and Eastern European catalyst for the dissemination of international thinking, both scholarly and managerial. To this end, the articles published in *Pannon Management Review* reflect the extensive variety of interests, backgrounds, and levels of experience and expertise of its contributors, both scholars and practitioners—and seek to balance academic rigour with practical relevance in addressing issues of current managerial interest. The journal also encourages the publication of articles outside the often narrow disciplinary constraints of traditional academic journals, and offers young scholars publication opportunities in a supportive, nurturing editorial environment.

Pannon Management Review publishes articles covering an extensive range of views. Inevitably, these views do not necessarily represent the views of the editorial team. Articles are screened—and any other reasonable precautions are taken—to ensure that their contents represent their authors' own work. Ultimately, however, *Pannon Management Review* cannot provide a foolproof guarantee and cannot accept responsibility for accuracy and completeness.

Contents

GYULA VASTAG

Editorial: Evidence-based science

The title of this editorial may seem tautological—the term 'science' derives from the Latin word *scientia* meaning knowledge, or the pursuit of knowledge, and knowledge is based on verified evidence. Nonetheless, we often come across such terminology—or one of its many variants (for example, evidence-based medicine, evidence-based decision making, and even evidence-based management)—in academic settings. Is it not obvious that science is based on evidence? If it were not, why would it be called science? After all, academic journals are supposed to publish scientific articles based on sufficient evidence for the claims they present—re-enforcing the obvious just seems tautological. This editorial attempts to address this perceived tautology by digging deeper into the meaning of evidence and the way science is developed.

Evidence is simply anything that supports a statement or assertion. In law, the phrase 'admissible evidence' defines the types of evidence that are acceptable in the proceeding—the quantity and quality of evidence necessary to meet the legal burden of proof are also specified. In medicine, evidence-based medicine has dedicated journals—for example, the 'Aims and Scope' of the journal *Evidence-Based Medicine for Primary Care and Internal Medicine* read as follows (EBM 2013):

> *Evidence-Based Medicine* [(EBM)] systematically searches a wide range of international medical journals applying strict criteria for the validity of research. Experts critically appraise the validity of the most clinically relevant articles and summarize them including commentary on their clinical applicability. EBM also publishes articles relevant to the study and practice of evidence-based medicine.

In a decade-old article in the same journal, Porzsolt et al. (2003) outlined a six–step approach to synthesising internal and external evidence for better health-related decisions. Internal evidence is the knowledge accumulated through formal education and training as well as through experience gained in daily practice or in individual clinician–patient relationships. External evidence consists of research results of randomised controlled trials—for example. It is therefore the combination and explicit contrast between internal and external evidence that elevates clinical decisions to evidence-based decisions. Conflicting internal and

external evidence leads clinicians to revisit one or the other—or to involve the patient in the decision-making process, as recommended.

Key to evidence-based medicine is the categorisation—or rating—of evidence, on account of freedom from bias. The strongest evidence is derived from multiple trials that are randomised, triple-blind, placebo-controlled with allocation concealment, and complete follow-up with homogeneous patient population and medical condition. Due to inherent bias, expert opinion, patient testimonials, and case reports are inevitably at the bottom of such hierarchy.

Perhaps less explicitly, fields other than medicine make similar attempts to increase the validity of research findings. They gather internal evidence through literature reviews, observations, case studies, or surveys, while meta-analytic studies tend to summarise available external evidence. Unlike medicine or physical sciences, the mechanisms—or the information available to evaluate the strength of evidence—are largely missing in management. There is no management equivalent for the medical trials which act as prime source of external evidence by serving as exact replications to verify and validate the findings of the original study.

In social sciences there are two types of replications—exact replications (replications with extensions included) and conceptual replications (Thomas and Rosquist 2003: 11). Exact replications—where the original study is repeated in every detail to verify the original results—are rarely pursued in management. The most common conceptual replications use different measures or conditions—different data sets, for example—to test the same or similar hypotheses. Conceptual replications are predicated on the idea that the effect—if large enough—will reoccur under different conditions. However, non-reoccurrence may be due either to the spurious nature of the effect or to the changes in research design. Consequently, conceptual replications open up a Pandora's box of issues, including the highly dubious 'inadequate treatment fidelity', where the failure to replicate results is attributed to improper implementation of research methods reported in the original paper—an argument that contradicts the large effect size-based foundation of conceptual replications.

The idea behind exact replications can be attributed to Karl Pearson, one of the great statisticians of the Twentieth Century, who issued the following challenge during a heated academic debate (Thomas and Rosquist 2003: 8): '[i]f a serious question has been raised, whether it be in science or society, then it is not enough to merely assert an answer. Evidence must be provided and that evidence should be accompanied by an assessment of its own reliability.' Statistics should be placed on the table for everyone to see, he argued—a recommendation not always followed in management, but without which the discipline has a long way to go to reach the level of an evidence-based science (Vastag et al. 2012).

The current issue of *Pannon Management Review* follows this recommendation to make management evidence-based (some pun intended). The first three articles link management and medicine by investigating management issues related to healthcare. **Thomas Lynch** and **Roderick Martin** examine healthcare systems from a macro perspective, while **Ágnes Lublóy** summarises current thought and reflects on managing the diffusion of pharmaceutical innovations. The last two articles explore the pursuit of knowledge through the turns and twists of PhD education. Preceded by an introduction by **Roderick Martin**, **Howell John Harris** gives a thoughtful and enlightening account of the beginning of his illustrious career as a business historian.

'For-profit Healthcare: A Lesson from Canada' by **Thomas Lynch** provides interesting bases for comparison with other healthcare systems—including Hungarian, where a (largely) not-for-profit system is mixed with for-profit elements—as well as possible lessons. The case discussed in this article is in the Canadian Province of Alberta, where private for-profit services were introduced into the public not-for-profit system, mostly on efficiency considerations.

Roderick Martin—in 'Recipe for Permanently Failing Organisations? Private Provision in Publicly Funded Healthcare'—discusses the potential impacts of the 2012–13 changes to the English National Health Services (NHS). Similarly to the Canadian case, the idea behind these changes is to enhance the role of market principles. However, because of a number of factors, the end result may be just a 'permanently failing organisation'.

Both these articles are very relevant for the reform of the Hungarian healthcare system—I hope we shall explore the issues presented here further in the near future.

Ágnes Lublóy—in 'Managing the Diffusion of Pharmaceutical Innovations: Conclusions from a Literature Review'—gives an overview of the quantitatively measurable and qualitatively accessible factors that influence new drug uptake in both primary and secondary care. It is perhaps understatement that the diffusion of pharmaceutical innovations is a very complex process. As her article shows, early adoption of new drugs is the result of multiple actors and multiple interactions that include the prescribing behaviours of doctors, their social networks, and the strategies and actions of pharmaceutical companies—all in a complex institutional setting of healthcare policies and regulations.

In the current issue of the journal, 'Young Scholars of Yesteryears' replaces our usual 'Young Scholars' Platform' to allow a few words of wisdom from two of those who have already 'been there and done that' successfully—**Roderick Martin** and **Howell John Harris**, who found themselves in a supervisor–supervisee relationship a mere 30–40 years back.

In 'Introducing Business Historian Howell John Harris', **Roderick Martin** discusses three fundamental prerequisites for successful PhD research: (1) pursue a

PhD if you have the drive and reason to do it—do not pursue a PhD just as a substitute for other options; (2) have a topic you are seriously interested in; and (3) pick your supervisor wisely. In my view, they should be made explicit in all PhD programmes and to all PhD applicants.

Howell John Harris recounts the beginning of his famed career in '"The Path I Trod": A Portrait of the (Business) Historian as a Young Idiot'. This is a highly personal, honest, self-deprecating, and entertaining account—with lessons for everyone in academia independently of the field studied—going back to times when Detroit could be found 'aesthetically exciting', in more ways than one.

Viewed through the lenses of this particular editorial, the articles presented here may be classified either as replication studies on the same question in not so dissimilar macro environments—**Thomas Lynch** and **Roderick Martin** are addressing the same problem of mixing a not-for-profit healthcare system with for-profit elements in Canada and, respectively, England—or as a source of external evidence—**Ágnes Lublóy**'s article provides external evidence from the literature on the diffusion of pharmaceutical innovations.

At their core, academics are evidence collectors—they build knowledge through amassing evidence from various sources. This is a 'trade' with its own rules, crafts, and even tricks, as well as with its own hierarchy—everyone starts at the bottom as doctoral students, and some rise to the top and become professors like **Roderick Martin** and **Howell John Harris** did. By sharing the story of how it all started, they are enlightening—I hope—many would-be evidence collectors.

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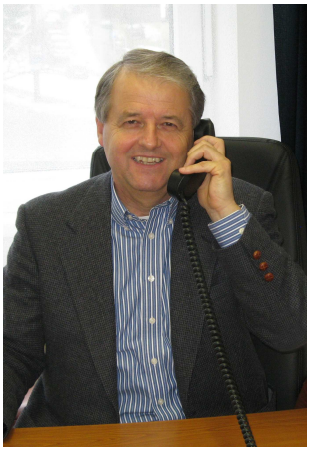

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Gyula earned his PhD and Doctor of Sciences degrees at (the predecessor of) Corvinus University and the Hungarian Academy of Sciences respectively, and finished his habilitation at Corvinus University.

His areas of interest include global operations and supply chain management, service operations management, and environmental management strategies. A successful and popular instructor, Gyula has developed and taught a wide variety of conventional and unconventional courses and educational programmes, both in business schools and for corporations—such as for the Kelley Direct Online MBA Program (Indiana University) and the action-learning programme for the executives of the largest bank in Central and Eastern Europe.

Gyula co-authored two books, wrote eight business cases, and contributed chapters to 15 books. He published over thirty peer-reviewed journal articles, in the US and Europe, and numerous papers in conference proceedings. The h-index of his publications in Harzing's *Publish or Perish* (based on over 1,000 citations) is 15 (as of 14 October 2012). His work on the competitiveness of metropolitan areas has generated interest outside academic circles, and his cases on Sonoco's take-back policy were selected by CaseNet® as two of the six e-link cases for the seventh edition of Meiners, Ringleb, and Edwards' widely used *Legal Environment of Business*.

Gyula has cooperated and consulted with a large number of organisations, including the Aluminium Company of America (Alcoa), the Carlson School of Management at the University of Minnesota, the Global TransPark Authority of North Carolina, the US Federal Aviation Administration, and the North Carolina State University, in the US; the International Institute of Applied Systems Analysis, in Austria; ESSEC-Mannheim Business School, in Germany; Knorr-Bremse Hungary and the OTP Bank, in Hungary; and the International Institute for Management Development (IMD) and the University of St. Gallen, in Switzerland.

Gyula is Member of the Executive Board of the European Decision Sciences Institute (EDSI) and the Vice-President for the European Division (2010–14) of DSI, where he is also Member of the Development Committee for Excellence in the Decision Sciences, the Nominating Committee, and the Strategic Planning for International Affairs Committee as well as Chair of the Member Services Committee (2011–14). He is Founding Member of the Global Manufacturing Research Group, where he also served as Associate Director. In addition, Gyula served on the Executive Committee of the International Society for Inventory Research in 1998 and 2006, and he is currently Member of its Auditing Committee.

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THOMAS LYNCH

For-profit healthcare: a lesson from Canada[1]

The extent to which health systems rely on for-profit mechanisms to deliver public health services varies and can be a source of tension for managers as well as politicians. Canada is generally understood to have a not-for-profit public health system that is frequently contrasted with that of the US, heavily reliant on market principles and price mechanisms.

This article examines Canada's public health system from the perspective of a single province—Alberta. In particular, this article examines Alberta's various attempts to introduce private for-profit services into a seemingly public not-for-profit health system. It focuses on a case study of the demise of a private for-profit surgical facility and examines factors associated with its failure.

Physicians are key actors in health systems. This article challenges assumptions held about physicians as policy actors and suggests that policy analysts and policy makers need to do a better job understanding the centrality of physicians for health policy outcomes.

The organisation and management of healthcare systems—whether in developed, developing, or broken economies—are a major preoccupation for politicians, public health managers, physicians, nurses, private corporations, citizens, and academicians. One important management and policy question for consideration is the role of for-profit, business incentives in the delivery of public healthcare. Public policy discussions frequently have to resolve conflicting viewpoints about how to achieve an optimal provision of public health service—whether clinical or non-clinical—in order to deliver value for money using price and for-profit mechanisms (Hawkesworth 2010: 10). This need for resolution usually relates to the depth of feeling accompanying debates about the role of markets and price mechanisms in the delivery of healthcare.

Viewpoints that favour for-profit healthcare usually consider two major perspectives: management and policy. The management perspective in favour of the for-profit approach in public health is that working through competitive markets builds more efficient service delivery pathways. It is claimed that having these pathways contributes to the optimum alignment between the demand for service and available resources (Mahar 2006: 83–6). The policy perspective

[1] Throughout, I have benefited from the expert advice of my wife, Janice Trylinski, a Canadian health lawyer who has worked in government as both a legislative draft person and a health policy analyst.

usually reflects the moral hazard aspect of public healthcare. Politicians on the right advocate the introduction of market and price mechanisms as a way to make people think twice before a health service is accessed. This perspective assumes that under a publicly funded not-for-profit model, people will over-consume healthcare services, perceived by the public to be freely available. This is the classic moral hazard perspective (Mahar 2006: 167–9). In Alberta, the moral hazard perspective was probably best epitomised in May 1993 by a Progressive Conservative government member during a healthcare debate (Legislative Assembly of Alberta 1993: 2593):

> The issue of overuse was also recently investigated by Dr. Howard Platt who published his findings in the *Alberta Doctor's Digest*, an Alberta Medical Association publication which goes out to 4,000 doctors in this province. Dr. Platt's findings showed that, in one particular area of southern Alberta, 44 percent of children under the age of 10 were taken to their doctors for common colds. [. . .] I find some of these facts alarming, but where do you put the blame, Mr. Speaker? It's not the fault of the doctors who are simply treating those people who walk through the door. Rather, the onus should be placed on the individuals who use the service; make them responsible.

Politicians on the left view the moral hazard problem differently. During the same debate, a member of the Alberta New Democratic Party rebutted the government member's comments (Legislative Assembly of Alberta 1993: 2593):

> So let's deal with the problem that the motion attempts to address: patient abuse. We know that it's not common; it's estimated to be under 3 percent. Just like the abuse of the social services system, it's hard to pin down. I want to ask you: who abuses the system? Not to put too fine a point on it: people who think that they're sick when they aren't abuse the system, but they themselves have a disease called hypochondria which needs to be treated. The other people who abuse the system are healthcare professionals—physicians, chiropractors, what have you—who call you back unnecessarily.

However, a child's 'cold' can be more than just a cold—and, surely, no not-for-profit public health system could depend on hypochondriacal patients for its survival.

There are also compelling arguments against for-profit healthcare from the US. Assessing the US health system, Relman (2007) presented the case against for-profit healthcare comprehensively and provided a superb assessment of the manner in which commercialisation and for-profit business incentives have saturated the provision of healthcare in America (Relman 2007: 15–39)—'[w]hen insurers and providers focus on maximizing their income, health care expenditures inevitably rise, equity is neglected, and quality of care suffers' (Relman 2007: 3). Physicians have been central to the process of commercialisation, through their own

investment in creating and owning for-profit health businesses, and such commercial involvement has undermined physicians' fiduciary duties to their patients (Relman 2007: 33). The US approach to health is probably the most commercialised in the world, he concluded, and other countries may not embrace commercialisation to the same extent (Relman 2007: 15).

In Canada, the publicly funded health system allows some room for private sector involvement in the delivery of a limited and specific range of healthcare services. The current breakdown between private and public financing of healthcare in Canada is as follows (Rachlis 2007: 3):

> In Canada about 70% of health care is financed publicly and about 30% privately. Twenty-five years ago about 76% of funding was public. Canada's rate of public finance is just marginally less than the average for the Organization for Economic Cooperation and Development (OECD) countries for 2005 of 72.1%. But almost all of the countries with comparable standards of living to Canada have a higher proportion of public spending because the average is brought down dramatically by the U.S., Mexico and Greece, where the public proportion of spending is less than 50%. Germany has 77% public proportion of spending, France 80%, Denmark and Norway 84%, Sweden 85% and the UK 87%.

This article reflects on the 'public–private split' in publicly funded healthcare from the author's perspective as both a medical sociologist and a practitioner of many years in a variety of public health policy roles in the Canadian health system. This article focuses on the ways in which the policy space in the Province of Alberta accommodated for-profit healthcare delivery as a specific management option during the period 1993–2012. In the context of this article, the term 'public health policy' means more than just policy designed to achieve health through improved sanitation, more comprehensive immunisation practices, and the provision of clean water and adequate shelter. Public health policy means the entire range of work and practices by which a variety of actors (governments, professionals, employers, and citizens) aim to create health as a state of being that reflects biological, physical, and emotional wellbeing and freedom from disease at individual and collective levels.

This hybrid of public policy and medical sociological analysis is meant to be illustrative rather than prescriptive. The Province of Alberta was chosen deliberately, as the jurisdiction where the author has lived, worked, and studied for about twenty years. Following this introduction, this article outlines a general analytical framework and provides a background description on the opportunity for private for-profit healthcare delivery options in Canada. It then focuses on a specific example of the way in which Alberta allowed private sector involvement in the delivery of surgical services and the problems encountered. The Alberta example is a specific instance of introducing market competition for the delivery of

hip, knee, and other orthopaedic procedures between the established public sector and a private sector surgical group based in Calgary, Alberta. It is an example of private for-profit delivery that ultimately fails. This business failure provides instructive value for policy makers and public health managers. This article concludes with an analysis and discussion of the lessons that can be learned from this Alberta experience.

Analytical perspectives

Based on the authors' shared and separate empirical work, the health policy framework developed by Klein and Marmor (2012) possesses an abstract quality useful to this present discussion—it deals with the worlds of politics and policy in a commonsense fashion that does not mystify the policy making process. Building on their health policy perspective, this article introduces some basic—but often ignored—theoretical and empirical content from medical sociology. Medical sociology considers physicians and physician organisations as policy actors crucial for public health policy design and implementation (Stevens 1998: xiv–xviii). The sociological content of this article will foreground a discussion about how policy interactions in the public health policy and management arenas can often go awry because the interests of a major interest group—physicians—are often misunderstood.

Klein and Marmor (2012: 1) defined public policy as a form of social action that is 'what governments do and neglect to do. It is about politics, resolving (or at least attenuating) conflicts about resources, rights and values.' Their framework rests on three key conceptual building blocks (Klein and Marmor 2012: 2–3):

1. ideas—the mental models (assumptive worlds) used by policy actors to provide both an interpretation of the environment and a prescription about how that environment should be structured;
2. institutions—the constitutional arrangements within which governments operate, the rules of the game, and the administrative machinery at their disposal; and
3. interests—specifically those operating in the political arena: material (primarily financial) and non-material (notions of right and wrong, for example); concentrated versus diffuse; and scale and intensity. The configuration of interests can change over time, as issues are redefined and new actors enter the policy arena.

For Klein and Marmor (2012: 4–5), the principal policy actors are political parties striving to gain office and form the government. Once elected in government, parties advance policies that maintain them in office, even if the policies of governing are not exactly the same as those on which they campaigned for office—such is the way of power. The ability of governments to craft policy is limited not just by the availability of resources required for policy implementation,

but also by the absence of perfect knowledge that ensures policies will work as intended and achieve the goals desired (Klein and Marmor 2012: 3).

Regardless of the prominence assigned to political parties, the public health policy field is also populated with other significant actors. Public health systems are a complex of professions, multinational corporate actors (such as GE or Siemens, which provide expensive imaging equipment, and international pharmaceutical companies), patient interest groups (such as the various regional Heart and Stroke Foundations in Canada), health philanthropies, and many others. These actors are frequently at odds with one another—their interests clash in ways that lead to differing stances on policy issues. The types of interest at stake when any particular policy issue arises can be as diverse as the autonomy to practice (in the case of professional associations), health priorities (whether limited funding should address prevention or cure), and governance (who gets to make the decisions about how services are organised and delivered).

However, physicians and their representative bodies remain the most important organised interest group from a public health policy perspective—despite the existence of other powerful public health policy actors, such as private for-profit hospital corporations, pharmaceutical companies, and insurance companies. If public policy is what governments do or neglect to do, then the strong corollary that this article wishes to draw for discussion is that the interests of physicians are the critical determinants for what governments eventually do or neglect to do when introducing public health policies.

This does not mean that physicians' interests are paramount, but that—as a practical issue—public health policies and public health policy analyses that do not factor them in are incomplete, even if these interests are judged to be minor. Understanding physicians' interests is complicated by the differentiated structure of the medical profession as it interacts within the political economy of public health policy making. Bucher and Strauss (1961) and Freidson (1986 and 1994) analysed this aspect of differentiation within the US health system and Marsden (1977) examined it from the Canadian perspective.

Bucher and Strauss (1961: 326) suggested that medicine as a profession can be viewed as a 'loose amalgamation of segments pursuing different objectives in different manners and more or less delicately held together under a common name at a particular point in history'—the unity of purpose that appears to mark medicine may be more manufactured than real (Bucher and Strauss 1961: 331–2). This model of the medical profession accommodates a 'divergence of enterprise and endeavour' which marks most professions (Bucher and Strauss 1961: 326). The appearance of professional unity—exemplified by codes of ethics, licensure rules, and disciplinary procedures—may hide from the public very real, very internal power struggles. This work of professional unification is often accomplished by key representatives within the profession who take on the roles of

negotiating and presenting its public face—an endeavour successful when people and policy makers approach the profession of medicine as a monolithic bloc.

However, in public health policy debates, interactions between physicians and governments can be difficult to interpret and manage—in the US, Canada, and elsewhere, the medical profession is not a monolithic bloc (Freidson 1994: 142–3). Freidson (1994: 196) differentiated three groupings that do the work of claiming and defending the professional status of an occupational group: the rank and file, the administrative elite, and the knowledge elite. The rank and file members of medicine are physicians involved primarily in clinical practice—they spend most of their time seeing patients. The administrative elite covers the executive, managerial, and supervisory roles in organisations and typically exercises some power and authority over rank and file members—vice-presidents of medical service in hospitals or health systems, for example. The knowledge elite—often referred to as academic physicians—advances and sustains the power and privilege of the profession through education of the next generation of medical practitioners and research into the cognitive / skill base that underlies the group's claims to professional status and sustains its claims for autonomy (Freidson 1994: 142–3). Most often, the work of the knowledge elite is translated into standards of practice—although these standards may or may not be adopted universally by the rank and file (Wennberg 2010).

The introduction of Canada's national Medicare Plan impacted relationships between government and physicians in the late 1960s and early 1970s. In Ontario (Marsden 1977: 8), for example, it enhanced the power and influence of the knowledge elite and created a different balance of power within the medical profession (Marsden 1977: 10):

> The Ontario Council of Health (OHC) has among its members a number of lay people; but of the doctors who have served on the main body [. . .] at least half have been doctors from the medical schools in the province. While doctors having any affiliation with a medical or teaching hospital are only a fifth of the doctors in the province, they are represented on the OHC in grater proportion than in the population of doctors. In 1971, for example, of the 21 Council members, seven were medical doctors. Of the seven, four were medical educators. On the Council's various other working committees and sub-committees, 53% of the doctors were educators.

The practical reason for this representative distribution had to do with the fact that academic physicians do not rely completely on clinical service for remuneration (Marsden 1977: 10), allowing them time and opportunity to interact with government, develop policy, and provide advice on implementation of new programmes.

From a public health policy perspective, success for political parties means crafting policies and programmes that provide a greater range of accessible, high-

quality, and affordable health services—and that lead a majority of electors to vote for them. From a political perspective, success is straightforward—winning health policy delivers electoral victory and avoids defeat. Once elected, the political party that forms government has to implement its policy, while dealing with a collection of groups that have diverse material and non-material interests as stakes in health system policy and implementation. The medical profession typically has a major voice and role in successful health policy development and implementation. However, because the medical profession is not monolithic, a predictable policy response from physicians to any particular policy idea is in no way guaranteed. On the one hand, Freidson's (1994) framework would suggest that the hour-to-hour operational success of broad health programmes—such as Canada's national Medicare Plan—rests with the rank and file physician segment. On the other, Marsden's (1977) research would suggest that this segment is probably the most challenging with which to consult on policy development and implementation. Her research pointed to the administrative and knowledge elites of the medical profession as the most commonly involved with the design and implementation of public health policy. The administrative and knowledge elites share some of the material interests of the rank and file, but they also have other interests—the promotion of education and research as activities within health systems, for example—as well as, perhaps, a stronger attachment to system administrative work. There is no reason to assume that the interests of the rank and file physicians dovetail with the standards work and scholarly interests of the knowledge elite or the administrative / bureaucratic ethos of the administrative elite. The Alberta example will be used to draw out this policy and management complexity as it manifested in one case.

Canada's constitutional framework for public health delivery

Canada is a federal democracy headed by a constitutional monarch and consisting of a federal government, ten provincial governments (including Alberta), and three territorial governments. The federal government retains primary responsibility for healthcare to aboriginals and certain public health services such as quarantine and food safety. However, public healthcare—the provision of hospital and long-term care and most community public health and physician services—is largely a constitutional responsibility of the provinces. The extension of public health as a national public programme in Canada was an initiative of the federal Liberal government through the *Medical Care Act* of 1966 (Government of Canada 1966). In the mid-1980s, after extensive federal–provincial negotiations, this act and its principles were reworked as *The Canada Health Act* (Government of Canada 1985). First in 1966 and then again in 1984,

the federal government and the provinces agreed to cost-share the provision of a set of insured public health services for a provincially delivered and managed health plan that satisfied five conditions—universality, comprehensiveness, portability, public administration, and accessibility.

These funding conditions were defined in the legislation, and provinces had to develop an insurance healthcare model that satisfied them, when the national physician and hospital services plan was started in 1966 under the *Medical Care Act*. The federal government determined compliance, and non-compliance through violation of the conditions resulted in financial penalties. However, the definitions of compliance were not absolute—with regard to access, for example, Section 12(a) of *The Canada Health Act* specified that access to insured services by insured persons need only be 'reasonable', without defining further what 'reasonable' meant.

Once it was determined that they complied with the five conditions, the provinces became eligible for full 50-50 cost-sharing from the federal government. The opportunity to deliver a politically popular programme with what was essentially 50-cent dollars was too attractive at the time to resist—all provinces agreed to cost-sharing with the federal government. Over time, the original 50-50 funding formula was substantially modified. Today, funding flows from the federal government to the provincial governments through the Canada Health Transfer—a combination cash–tax point arrangement between the provinces and the federal government, renegotiated from time to time and currently accounting for about 22 per cent of provincial spending on healthcare.

The federal government uses renegotiations to make provinces more accountable for delivering programmes and services in ways consistent with the original five conditions. However, the provinces argue that calls from the federal government for greater accountability may represent federal intrusion—after all, the constitutional responsibility for public healthcare lies within provincial jurisdiction. Rather than greater accountability, their view is that what is required is greater flexibility from the federal government as to how the money is spent provincially. The federal government's cash and tax point contributions are inadequate to meet the need of their populations, argue the provinces—the decreased federal proportional share of healthcare funding now means that the federal government is seeking constitutional control over health that outweighs its financial commitments. The political dynamic created by the accountability–flexibility tension has resulted in conflict and a degree of diversity. Provinces attempt to push back the limits of federal authority and, in so doing, test the federal government's resolve to enforce the five conditions. Provinces particularly resent federal attempts to use spending powers to adjudicate the administrative propriety of various mechanisms that provinces might choose to manage healthcare locally—

for example, service delivery 'experiments' that include private for-profit models of healthcare delivery.

Today, Canada's national health system consists of ten separate provincial health plans knitted together by the five federal funding criteria and the cost-sharing formula in place at any one time—each province's approach to public health delivery reflects its particular political, social, and economic context. Despite such tensions in the Canadian public health system, innovation is intrinsically possible within the national plan's design because the five founding criteria are actually vague and open to a broad degree of interpretation.

There are several ways in which Canada can be said to have mixed, public–private delivery and for-profit–not-for-profit financing models for public healthcare. First, according to the 'Interpretation Section 2' of *The Canada Health Act*, only physician services that are medically required are insured—non-medically required services (such as cosmetic surgery, for example) are not. Second, the public system pays for private and semi-private hospital room care only if required for medical reasons In other words, *The Canada Health Act* only mandates provincial coverage of medically necessary physician and hospital services, resulting nonetheless in about 91 per cent of hospital bills and 99 per cent of physician bills being paid publicly (Rachlis 2007: 3). Patients must pay out-of-pocket for private and semi-private hospital room care for non-medical reasons (such as privacy, for example). Patients' private health insurance is often with insurers (such as the provincial Blue Cross Plans, for example) that operate as non-profit corporations under provincial insurance regulations—under the public administration criterion, *The Canada Health Act* allows provinces to delegate part of their responsibility for coverage to a third party that is a non-profit entity. Third, the provincial Workers' Compensation Boards were explicitly exempted from *The Canada Health Act*—the 'Interpretation Section 2' excluded workers' compensation health services from the definition of insured medical services. These provincial agencies can thereby purchase medically necessary services for injured workers from any healthcare providers—including for-profit providers, where such providers exist. Fourth, public healthcare provision for certain groups—on-reserve aboriginals, members of the Royal Canadian Mounted Police, and members of the Canadian Armed Forces, for example—is the responsibility of the federal government.

For-profit orthopaedic surgery care: the Alberta case

For the last 20 years, the Canadian Province of Alberta has had a consistent political desire to introduce some degree of private sector involvement into the delivery of clinical services. Alberta has had a unique political history, having

been governed for about eighty years by two centre-right parties—the Social Credit Party of Alberta and the Progressive Conservative Party of Alberta (herewith, the PC Party). Under a succession of leaders, the PC Party has governed Alberta for the last 42 years, during which time political opposition has been minimal. In a Westminster first-past-the-post electoral system, the PC Party has typically won resounding majorities—in many constituencies, its margin of victory could be modestly described as a landslide. These electoral majorities, particularly over the last 20 years, frequently occurred against a background of electorate concern over long wait times in emergency departments, long wait times for elective surgical services, and shortages of physicians and other health professionals. There have been strikes and disagreements between the Government of Alberta (as the employer) and health professions and occupations (as workers, physicians included). Election and pre-election opinion polling of the population often suggested that healthcare delivery and access to healthcare services were major public concerns. Nevertheless, the PC Party has been resoundingly victorious at re-election—the public perception of poor healthcare delivery and inadequate access revealed through opinion polls and public sector worker strife has had no detectable political impact at the ballot box. Today, Alberta receives significant funding from the federal government and operates a publicly funded health system that is substantially consistent with the principles of *The Canada Health Act*.

In 1993, the PC Party government in Alberta initiated a major redesign of public healthcare delivery and financing, as part of a broader plan to reduce overall government spending and accumulated debt which had come about from the collapse of oil and natural gas royalty revenues in the late 1980s (Flanagan 1998: 20). This initiative centred on the creation of regional health authorities—legal entities established under provincial legislation to plan, fund, and deliver comprehensive public health service coverage for the populations of defined geographical areas within Alberta. Alberta's regional health authorities became responsible for the governance of hospitals and other public health services, as well as the budgets for their operation. For the most part, physician billing and remuneration remained outside the regional health authority system.

Under the *Regional Health Authorities Act* (Government of Alberta 2009), health regions were given broad powers to explore different mechanisms for delivering health services, including contracting out with private for-profit and private not-for-profit providers. While this redesign of governance and service delivery was underway, the provincial government made several attempts to introduce a greater degree of private market forces into healthcare and, in the spring of 1998, introduced legislation giving the Minister of Health powers to approve private hospitals. Although public opposition was intense and the bill was withdrawn (Steward 2001: 34), the provincial government did not relent—in 2000, it passed the *Health Care Protection Act* (Government of Alberta 2010) which

remains in force today. Carefully drafted and worded, this created the legal framework within which a private for-profit healthcare market could develop in Alberta around surgical services.

The first part of the for-profit health strategy involved lulling the public—Section 1 of the *Health Care Protection Act* prohibits any person from operating a private hospital in Alberta. The second part of the for-profit health strategy was to create a legal structure within which a market could nevertheless evolve—Section 2(1) of the *Health Care Protection Act* specifies that no physician can provide an insured service in Alberta unless in a public hospital or an 'approved surgical facility', while Section 4 prohibits operators to bill for 'facility services' over and above the amount agreed in the contract of operation with the regional health authority. Moreover, facility services—defined in Sections 29(g)(i) to 29(g)(xii)—are restricted to medically necessary services directly related to the provision of a surgical service at an approved surgical facility. However, section 29(g)(ix) deftly places the following qualifying clause within the definition of a facility service: 'medical goods or services consistent with generally accepted medical practice in the particular case'. The cumulative impact of these sections is that operators of surgical facilities can charge patients directly for enhanced facility service options, as long as such facility service options are not medically required relative to the surgery in question—purchasing gourmet meals and fine wines during a surgical stay, for example, or even better quality hip and knee prostheses than those consistent with the generally accepted medical practice. The College of Physicians and Surgeons of Alberta (CPSA) was empowered to perform the accreditation of private clinics. By 2012, 60 independent clinics across Alberta were performing surgeries outside of hospitals—of these, 12 were performing multiple types of surgery (Gibson and Clements 2012: 7).

The political appetite to grow private for-profit medicine was most intense during the 1990s and early 2000s in Calgary. Politically, the city has been a long-time bastion of conservative politics—two of the longest serving premiers during the PC Party's 42 years in power were elected from Calgary. In Calgary, the regional model of health system governance went through three iterations—from the Calgary Regional Health Authority, through the Calgary Health Region, to the provincial amalgamation into a single region known as Alberta Health Services.

The Calgary Regional Health Authority developed a history of contracting out surgical services to private for-profit clinics beginning at least as early as 1995 (Steward 2001: 13). These contracts covered a broad range of surgical services—including ophthalmology; abortion; ear, nose, and throat; podiatry; dermatology; oral surgery; and publicly insured dentistry procedures—and the contracting process had some interesting local features (Steward 2001: 13–14). First, the largest contract (for eye surgery) was awarded to a private for-profit clinic partly-owned by the Division Chief of Ophthalmology at the Calgary Regional Health

Authority. Second, a contract for podiatry surgical services was awarded to a private for-profit clinic partly-owned by the Chief of Orthopedics at the Foothills Medical Centre, the largest acute care hospital in Calgary with a major academic role. Third, in 2000, two contracts for eye surgery were awarded to Surgical Centres Inc., a company where the Chief Medical Officer and Senior Vice President of the Calgary Regional Health Authority and his spouse were part-owners. The pattern is distinct—physicians who can be best described as prominent members of the administrative elite of the Calgary medical profession took leading roles in the privatisation of clinical health services.

In 2003, the College of Physicians and Surgeons of Alberta accredited Calgary's Health Resource Centre (herewith, Centre) to deliver surgical care with overnight stays. The Centre had previously been incorporated as the Health Resource Group (herewith, Group)—a surgical consortium that focused the majority of its business on providing day surgical services to third-party payers such as Workers' Compensation Boards, private insurers, and out-of-country patients. The Group had received accreditation from the College of Physicians and Surgeons of Alberta to offer only day surgery without overnight stays (CUPE 2000: 8).

How commercial or corporate was the Group as it transformed into the Centre? In its analysis of private healthcare in Alberta, the Canadian Union of Public Employees (CUPE 2000: 10) noted that the Group had multiple private investors in 1998—the Group was a privately held registered company that paid taxes and offered dividends to its closed group of investors. Its Board of Directors included locally prominent Calgary business leaders, such as the former President and Chief Executive Officer of the Alberta Children's Hospital, the President of the Calgary 1988 Olympic Organizing Committee, an architect whose spouse was a Member of the Legislative Assembly of Alberta (MLA) representing a Calgary riding[2], and a prominent Calgary orthopaedic surgeon who already had a private business servicing Workers' Compensation Board patients. Another prominent member was a physician who had been the founding Dean of the Faculty of Medicine at the University of Calgary, and who had since moved into the medical research venture capital business—his career as a physician clearly spanned several professional segments, but at that particular stage and in those particular circumstances he was acting as an investor seeking returns, not as a member of the medical profession's knowledge elite.

The Centre was owned by its parent company, Networc Health Inc. (Gibson and Clements 2012: 6), whose Chief Medical Officer was an orthopaedic surgeon who had been chief of orthopaedic surgery at the Foothills Medical Centre in Calgary as well as Medical Director of the Group. A physician drawn from the mid-echelon

[2] Electoral district.

of the administrative elite of the local medical profession, to use Freidson's terminology, his interests would have been more aligned with those of the rank and file and those of the administrative elite than with the interests of academic physician colleagues in the knowledge elite. The knowledge elite of the medical profession in Calgary controlled the Faculty of Medicine, and had succeeded in achieving administrative control at the Foothills Medical Centre.

As regional health system governance evolved, the reorganisation of services away from the hospital model to the regional model was accompanied by a novel physician management strategy that substantially altered the traditional relationships among different segments of the Calgary physician population. The Calgary Health Region and the Faculty of Medicine at the University of Calgary reached a new accommodation with regard to clinical and academic activities—with a few minor exceptions, one person was to cover both clinical and academic leadership roles, and was to lead both organisations. In so doing, the Calgary Health Region was recognising the city's importance in the academic health sciences and was accepting the need for organisational integration between the service and scholarly missions of the Faculty of Medicine at the University of Calgary, on the one hand, and those of the city, on the other.

This innovation is worth bearing in mind, when considering the policy and service developments that occurred on parallel tracks in 2003–4.

Soon after its accreditation in 2003, the Centre entered into a contract with the Calgary Health Region to provide hip and knee replacement surgery as part of the plan to reduce wait times for this surgery. This was a sole-source contract, initially, as there were no other providers of this service that could deliver overnight stays during recovery (Gibson and Clements 2012: 8). However, the arrangement proved problematic. Originally, in 2004–5, the Centre had a single contract for orthopaedic surgical services, valued at CAD 2.1 million (Gibson and Clements 2012: 9). By 2009–10, the Centre had four contracts—one covering orthopaedic surgical services, one covering acute post-operative and sub-acute services, one covering internal medical consultation services, and one for an outpatient services agreement—worth CAD 8.3 million (Gibson and Clements, 2012: 10–11). Over time, as the contracts increased in size and became more diverse, Networc Health decided to expand the Centre and improve its physical space in order to accommodate requests for increased surgeries from the Calgary Health Region. About this time, the regional model of governance changed again, and all Alberta health regions were amalgamated into a single region known as Alberta Health Services. When absorbing the Calgary Health Region, Alberta Health Services took on the previous regional contracts with the Centre.

In 2004, the Government of Alberta had initiated an evidence-based pilot project to address wait time challenges in the knee and hip replacement field (Gibson and Clements 2012: 11). To this end, a province-wide pilot project

partnership was developed among the provincial Ministry of Health, the Alberta Orthopedic Society, the Alberta Bone and Joint Institute, and family physicians from across the province who initiated referrals. This pilot project included the Centre facility and surgical workloads in the study. A prominent orthopaedic surgeon—who was a Calgary academic physician and clinical and scientific leader of the Alberta Bone and Joint Institute—championed the pilot project and led its research evaluation. He had been a national scientific leader with the Canadian Institutes of Health Research, and he had played a significant role securing philanthropic and government financial support to build a large, new surgical wing for bone and joint surgery at the Foothills Medical Centre—where he practised—that would be publicly funded as a public hospital facility and therefore as a non-profit venture.

The outcome of the pilot project was a new evidence-based continuum of care that was rolled out in major urban centres across Alberta in a major effort to reduce provincial wait times for hip and knee joint surgery. The pilot project demonstrated that—with a realignment of resources and evidence-based clinical pathways—it was possible to deliver enhanced care within the public not-for-profit system that reduced wait times and provided benefits to patients cheaper than private for-profit alternative providers (Gibson and Clements 2012: 11). This outcome was critical in the Centre's ultimate slide into bankruptcy.

A subsequent Alberta Health Services internal economic analysis and comparison based on the pilot project results indicated that the Centre could not provide surgical services at a price competitive with the public not-for-profit system (Gibson and Clements 2012: 12)—the Centre's higher costs per case were attributed to factoring into its business model a pre-tax return on investment of 10 per cent. The management irony was that—through successive reorganisations (from Calgary Regional Health Authority, through Calgary Health Region, to the province-wide Alberta Health Services single-region)—the public provider had acquired the scale required to offer much more cost-efficient orthopaedic surgical services. Alberta Health Services decided not to increase the surgical volumes of the Centre any further.

The Centre's ending was neither elegant nor graceful. The space expansion undertaken by Networc Health to accommodate the previously increasing surgical contracts led to financial difficulties. In 2010, the Centre's landlords, the Cambrian Group, initiated an unexpected bankruptcy order against Networc Health, alleging amounts owing from unpaid leases in the order of CAD 630,000[3] (Gibson and Clements 2012: 10).

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[3] For full details from the Centre's perspective, see Osler, Koskin & Harcourt LLP (2010).

Alberta Health Services intervened in the bankruptcy proceeding between the Cambrian Group and Networc Health / the Centre, requesting and paying for an interim receiver and purchasing the Centre's debt and security—this 'gave Alberta Health Services status as creditor and the presence of an interim receiver enabled them to delay bankruptcy proceedings' (Gibson and Clements 2012: 10). Alberta Health Services wound down the Centre—which happened to coincide with the opening of a large, new hospital wing by Alberta Health Services at the Foothills Medical Centre with a major focus on orthopaedic bone and joint surgery. Thus ended this particular experiment with the private provision of orthopaedic surgical services in Calgary.

Discussion and conclusions

That a private sector company such as Networc Health / the Centre should go bankrupt is hardly surprising. Bankruptcy is as common an occurrence in the private sector as corporate mergers and takeovers. Such is the way of markets—price competition creates corporate winners and losers.

Today, private sector, for-profit involvement in the financing and delivery of healthcare services in Canada is probably best characterised as moderate. The principal economic rationale advanced by Canadian advocates of free market principles in healthcare is that market incentives and structures can bring efficiencies to the delivery of healthcare (Flanagan 1998: 25). In terms of a day-to-day management strategy, the private sector, market-driven approach is most commonly advocated as a way for Canada to deal with long wait times for service (Rachlis 2007: 1). Rachlis (2004: 302–5) suggested that—while there may be a role for the private sector in Canada's healthcare system—any such role is probably limited at best for a variety of technical reasons having to do with the requirements of private sector, market-driven healthcare delivery:

1. low contestability. Market conditions make it difficult for many firms to enter healthcare. For instance, not many companies can afford to buy a hospital, attract doctors and other staff, and meet all the regulatory requirements for health service delivery.
2. high complexity. Health services may often have—frequently multiple and at times conflicting—policy goals. For instance, while a major goal of a health programme may be to increase or improve access to primary healthcare, this goal can be at odds with the goal of providing care within reasonable cost parameters.
3. low measurability. Specifically related to quality—and the inability to adequately rate the quality of many health services in a readily quantifiable way that is reliable and reproducible. Quality measurement in healthcare frequently

means an assessment of work practices by professionals and quasi-professionals that can become an enormously contested practice.

4. cream skimming. This is a better-known flaw of private sector approaches, whereby the private providers organise in a way that allows their participation in healthcare delivery to service the most easily diagnosed and treated patients, while the public system serves the harder to diagnose and treat and more complex patients, who are usually the more costly.

Flanagan (1998: 25) went even further and argued that the circumstances for an efficient market solution do not exist at all in the Canadian healthcare system—market success requires competition where numerous autonomous producers survive only by producing efficiently, at the lowest costs of production.

From a healthcare management perspective, the Group / Centre experience as a for-profit option illustrates how the absence of clear costing methodologies that ensure 'apples' are being compared with 'apples' is a major evaluative obstacle for determining which approach works better. William and Eisenberg (1991: 71–90) admirably explained how this problem can occur on multiple levels of method and analysis. First, healthcare costing methodologies can be hampered by a basic confusion between efficacy (whether a specific type of care works) and efficiency (what a service costs relative to its benefits). Second, whether evaluating healthcare issues from efficacy or efficiency perspectives, healthcare costing methodologies have to assess and compare the direct, indirect, and intangible costs of service provision. When evaluating the pilot project, the comparisons the Alberta Health Services made were based on average costs, and should have accounted for the administrative costs of contract administration. With Alberta Health Services being a CAD 12 billion-budget organisation and the Centre being a CAD 8.3 million-revenue organisation, the validity of the cost comparisons is unclear—without access to the contract, an independent verification is impossible. Lastly, third, it is difficult to determine whether the prices charged by private or public providers are fair and reasonable. In the particular case of the Centre's demise, the following particular features need to be noted:

1. The Centre operated as a sub-contractor to the public system and could not 'carry on its business of publicly funded, privately delivered surgical services except as and to the extent' that the public provider—Alberta Health Services—agreed (Gibson and Clements 2012: 15).

2. The most recent history of healthcare privatisation in Alberta—with its diffusion of market-oriented approaches to healthcare delivery—coincides with regionalisation as the dominant governance model. Within this governance model, efforts to increase a market-driven service delivery approach seem replete with physicians who were in leadership positions in these regions. These physicians were essentially carving out deals with and for themselves. This is a poor and ethically questionable practice.

3. Gibson and Clements (2012: 13) noted that private providers usually only 'do' non-complicated cases, leaving the more mixed and challenging caseload to the public system. This is the 'cream skimming' technical issue noted earlier by Rachlis (2004).

In fairness to the Centre, it is not at all clear whether the decision to cancel its surgical contracts was made for strictly economic reasons. With a significant new surgical wing—that could accommodate the surgical volumes being done at the Centre—opening at the Foothills Medical Centre, perhaps the political need to ensure that this new surgical capacity was effectively utilised weighed into the Alberta Health Services decision making. A very real political lesson from this experience would seem to be that—in making deals with governments and their agents—constancy of purpose may be elusive. Governments and their agents can be fickle, and those who expect constancy from them are often disappointed.

The Centre's demise also illustrates that non-obvious tensions and conflicts in the medical profession need to be better understood, when studying public healthcare policy issues. The Centre's focus was the provision of surgical services and not education or research—the Centre was a facility dedicated to the type and style of work that would be of most interest to the rank and file segment of the medical profession. Orthopaedic surgeons' and anaesthetists' participation likely provided them with an additional opportunity to maintain their skills, as limited operating theatre time in the public system can be a liability for a specialty group that relies on volume to maintain craft. Presumably, the physicians who worked at the Centre did so because it was financially lucrative, it allowed them to address patients' needs, and probably it allowed them to practice in a facility other than the Foothills Medical Centre, which was the major Calgary teaching and research hospital controlled by academic physicians. A medical politics challenge for the Centre was that it provided rank and file orthopaedic surgeons and anaesthetists an opportunity to practice away from the academic physicians who were in control at the Foothills Medical Centre. Academic physicians who educate future physicians need to ensure that students and postgraduate resident physicians have access to a sufficient range and volume of morbidity[4] and pathology[5] to ensure adequate education experiences. The Centre's success growing its surgical business over time was a potential challenge to the continued viability of the surgeon-in-training education that could be offered by the knowledge elite segment in the not-for-profit public system. These 'town versus gown' tensions are rarely mentioned in the public health policy literature, even though they are real and tangible factors dictating how different physician segments approach policy issues.

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[4] The rate of incidence of a disease.

[5] The manifestations of a disease.

Similarly, tensions regarding the way different segments are remunerated are rarely factored into public health policy discussions of for-profit care. How physicians are paid in Canada and what constitutes their fees have an impact on the general context within which for-profit healthcare becomes an option, as well as on how the different segments relate to one another. Canadian physicians are normally remunerated for their clinical services on a fee-for-service basis. In each province, these fees are set following negotiations between a physicians' association and the provincial government. Because physicians are viewed as small businesses, the fees negotiated include a component to cover office overhead expenses such as the employment of a secretary, rental of a clinic space, and other such expenses usually incurred by small business. This portion of the fee may represent on average 40 per cent of the charge. Technically, the extent to which physicians can manage their practice with less than 40 per cent overhead constitutes a profit for the practice. In Alberta, it is not unusual for all physicians—rank and file, administrative elite, and knowledge elite segments—to be incorporated as businesses for their clinical time. The reasons are simple—tax advantage and the ability to be more creative with a retirement savings strategy. In the case of the knowledge elite, academic physicians generally incorporate for their clinical time, while being employees for their university appointment time. It can be reasonably concluded that—on a formal basis—much of Canada's public health system is delivered by private sector businesses owned and operated by physicians. It may be a reasonable assertion that a business ethos is pervasive throughout Canada's public healthcare system—although, in the author's experience, critics of for-profit healthcare delivery rarely, if ever, concede this point. It may even be worth considering whether this business ethos is a major component of most public healthcare systems sanctioned by governments anywhere in the world.

The Alberta case study discussed in this article suggests that the interests of physicians are not monolithic when it comes to the political economy of health system policy making and management. It may be imprudent for policy makers to assume that physician participation in policy making and management processes is guided solely by the needs of—and demand for—high-quality, reasonably priced, and accessible clinical services. Health systems also support significant scholarly enterprises of intense interest to the knowledge elite segment. The integration of the scholarly and clinical service missions that happened in Calgary is not common across Canada and may not be common in other national health systems. It may be a feature too unique to this case study to be specifically useful elsewhere. However, it does highlight the need for policy makers and public sector managers to give some degree of thought to how very different outputs and outcomes can be at stake in public health policy and management for different individuals in the same professional group.

Going forward, it may be timely to re-examine the role and possibility for private for-profit providers as players in publicly funded health systems. Engaging for-profit providers may be possible, if governments and other public funders give care and attention to the outputs around quality, safety, and access in such a way that both not-for-profit and for-profit providers play within a shared and transparent set of rules. Whether as for-profit players who generate revenues for shareholders or not-for-profit players who generate budget surpluses, as long as they are tied to requirements for safe, high-quality, and timely care provision, the public will be the major beneficiary. This is a task for the regulator that in most instances is a government—ultimately, clear expectations and rules around safety and quality may be even more important for providers, whether they are for-profit or not-for-profit operators.

Approaching the question of the public–private split with these considerations in mind raises a fundamental theoretical question—is not-for-profit public healthcare in Canada or elsewhere at all possible? For example, major equipment—such as magnetic resonance imaging (MRI) machines—is purchased with public dollars from large multinational manufacturers such as GE or Siemens. Even though the public tendering and bidding processes can be rigorous, the health businesses of GE and Siemens continue to be profitable, and some of their profit gets reinvested into research and development to improve technologies. Should the profit amassed by a large international corporation such as GE or Siemens be considered as different from profit amassed by businesses owned and operated by incorporated physicians? This is an important question to consider, but not here.

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Tom's areas of expertise are the sociology of healthcare and the sociology of the professions. He received his PhD in 2007 from the University of Calgary, having studied and researched his dissertation topic under the supervision of Dr. Arthur Frank. As a sociologist, Tom would classify himself as a mixed-methods critical sociologist who strongly favours the theoretical perspective developed by the late Pierre Bourdieu. His dissertation was a study of academic medicine in Canada using Bourdieu's analytical framework and a qualitative approach interviewing deans of medicine and academic and university leaders across Canada.

One of the more interesting aspects of Tom's PhD training is that, throughout, he maintained a full-time job as Director of Strategic Planning for the Faculty of Medicine at the University of Calgary. At the time, he had the great good fortune to work for an astute and enabling Dean, the late Dr. Grant Gall, who encouraged academic development and was supportive of his doctorate. This was one of a series of jobs in academic medicine that Tom held across a 25-year span. Early in his career, he had more of a hands-on, quantitative focus and conducted several population health surveys and health programme evaluation studies in various provinces. Progress through the health management field involved working in a variety of policy roles across multiple sectors, from provincial ministries of health to the non-governmental health advocacy sectors. Working most often directly in support of chief executive officers allowed Tom a view into the makings of public health policy at the very highest levels. He also had the opportunity to engage in

high-level political advocacy. These experiences shaped Tom's view of both the art of strategy planning and the craft of policy making and implementation.

Following his PhD, Tom had the opportunity to engage with the Center for Policy Studies (CPS) at the Central European University (CEU) as a Post-doctoral Research Fellow. He spent the period September 2010–August 2012 in Budapest, Hungary, and became aware of the challenges facing public health systems in post-communist states. Tom learned a great deal at CEU with a group of bright, hard-working, and kind colleagues and associates—all of whom he considers friends.

Currently, he is interested in further research into how the commercialisation of public policy research occurs through the use of consulting firms and think-tanks and the roles of physicians in these organisations. With more time, Tom would like to explore the ways in which personalised medicine and genomics are disseminated into medical practice and how professions—such as engineering, medicine, and the law—approach major policy game-changing events such as climate change.

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RODERICK MARTIN

Recipe for permanently failing organisations? Private provision in publicly funded healthcare[1]

This article outlines the radical management changes introduced by *The Health and Social Care Act 2012* (HSCA) in the English National Health Service (NHS) in 2013 and discusses their possible effects on NHS as an organisation. This article argues that the HSCA reforms—designed to enhance market principles—represent a political solution to management problems, driven by financial and ideological priorities. Because of conflicting objectives, unclear distribution of authority, organisational complexity, and lack of sensitivity to the NHS' historical culture and structure, the outcome may be a 'permanently failing organisation'.

Healthcare is a major preoccupation for governments, as for individual citizens. In 2010, expenditures on healthcare represented 11.6 per cent of GDP in France, 11.6 per cent in Germany, 9.6 per cent in the UK, and 9.1 per cent in Austria. For the US, the figure was 17.6 per cent—for Hungary, 7.8 per cent (OECD 2012). For England (not the whole UK), the GBP 20 billion budget in the financial year 2012–13 dwarfed expenditure on education and defence combined—the National Health Service (NHS) employed over a million people. The rate of increase in healthcare expenditures is greater than the rate of increase in expenditures in other areas, due to ageing populations with greater healthcare needs and increasingly sophisticated and expensive medical technologies, and with inflation in pharmaceutical costs rising more rapidly than general inflation. In Europe, life expectancy is rising, but the experience of old age is increasingly characterised by ill health. Against this background, the management of healthcare has become a major issue. Drawing on the English experience, this article argues that the application of market principles to healthcare provision is unlikely to improve healthcare management performance—and may even damage it.[2]

With the extension of market principles to NHS, the British government has launched a massive experiment in managing healthcare. NHS is unusual in providing publicly funded healthcare, free at the point of need. The system—established in 1947 by the Labour government of the time—was not copied by

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1 This article stems from *The Future Organisation of the NHS*, a memorandum submitted to the Public Bill Committee on the Health and Social Care Bill (Martin 2011).

2 NHS England, NHS Northern Ireland, NHS Scotland, and NHS Wales are managed differently—the analysis in this article refers to NHS England.

other advanced economies, which instituted various forms of insurance–based systems, with some public funding, as in France, Germany, and Scandinavia. The NHS model was similar to socialist healthcare systems. Historically, NHS has been the major means of providing healthcare, managed as a single public sector organisation through regional strategic health authorities (SHAs) and local primary care trusts (PCTs) (with different names at different times). In addition to public provision, private care has always been available, both for general medical services (medical examinations for life insurance, for example) and for specialised medical purposes (in vitro fertilisation, for example, for a time). Private patients were able to arrange medical appointments at their convenience, not at times specified by the doctor, and a small number of procedures were not available through NHS. Such private treatments were normally covered by insurance—through Bupa (the British United Provident Association (BUPA), originally), for example, sometimes funded by employers.

The NHS management structures and procedures were transformed by the implementation of *The Health and Social Care Act 2012* (hereafter, HSCA), which came into operation on 1 April 2013 (HM Government 2012). Although the basic principle governing healthcare—free of cost for the patient at the point of need—remained unchanged, the management means to implement this principle changed dramatically. The managed market became the mechanism underlying the new system for healthcare provision, with separation between purchasers and suppliers—and competition among suppliers on the basis of quality and price—replacing a national, largely bureaucratic structure. General practitioners (GPs)—acting for the patients registered on their general practice lists—remain the purchasers, using NHS funds and operating through purchasing consortia, but the suppliers are no longer necessarily NHS organisations. HSCA abolished the previous structure of regional and local offices. Instead, the new structure (see Figure 1, p. 36) comprises local GP commissioning consortia (GPCC), consisting primarily of GPs supported by professional financial managers. GP commissioning consortia are responsible for providing primary care and for purchasing clinical treatment from providers—often, but not invariably, from NHS hospitals, themselves reorganised into independent trusts (DH 2011b). Coordination is achieved through four NHS regional commissioning offices and 27 local area teams (LATs). A central NHS Commissioning Board (NHS CB) is responsible for managing the system, together with a central Monitor—responsible for overseeing quality, innovation, and competition—and a central Care Quality Commission (CQC).

The reorganisation seeks to achieve three stated objectives, according to HSCA. The first objective is to increase freedom of choice for patients, with GPs required to inform patients of the availability of different suppliers for the medical services they—on GP advice—require. This follows common practice under the pre-2013

system. The second objective is to improve the quality of patient care—and to accelerate innovation—through increasing competition, and through expanding the financial resources available to the industry from the private sector. The third objective is to improve cost effectiveness, within the context of a large, annually set, nominally protected budget—GBP 20 billion, approximately, in 2012–13. The objectives are to be achieved through increasing competition, both within NHS itself and between public and private sector suppliers—'Any Qualified Provider' (AQP) approved as meeting the performance criteria established by the NHS Commissioning Board. HSCA sought to provide the institutional means for effective, transparent market operations and contained detailed provisions concerning procurement arrangements—including bidding processes—and shortlisting procedures, and for monitoring transparency in the allocation of contracts.

Private sector involvement in British healthcare is not new—NHS has always been a mixed economy, not a fully state-planned economy. GPs are independent professionals, responsible for maintaining their own surgeries and support staff, operating in effect as small businesses, with funding primarily from fees from the state. Hospital consultants engage in private practice, treating both domestic and international patients, alongside NHS patients—consultant contracts are based upon undertaking an agreed number of NHS sessions, allowing mainly senior consultants to treat patients privately at other times, often using NHS facilities. Large numbers of dentists, pharmacists, and opticians provide both private and publicly funded services, the latter according to a table of fees and charges established by NHS. HSCA provides for a massive expansion in the private sector, with increase in existing privately financed services, as well as entrance of new private firms into service provision—Circle has operated Hinchingbrooke Health Care NHS Trust in Huntingdonshire under franchise arrangements on behalf of NHS since early 2012 (the first to do so in England). Major international medical corporations—including HCA International (the international arm of Health Corporation of America (HCA)) and BMI Healthcare (owned by the South African company Netcare through the General Healthcare Group (GHG)) (NHS Support Federation 2012: 7–16)—undertake routine operations and specialised treatments. In future, hospitals will be permitted to use up to 49 per cent of their beds and operating theatre time for private patients, compared with fewer than 5 per cent under the former system. HSCA provisions regarding competition encourage the large-scale growth of private providers, purchasers being prohibited from excluding private Any Qualified Providers from lists of suppliers, except under a very limited number of specified circumstances. The expansion of private sector provision raises possible issues of competition policy and market regulation (see pp. 42–3). Opponents of the new management system perceive creeping privatisation.

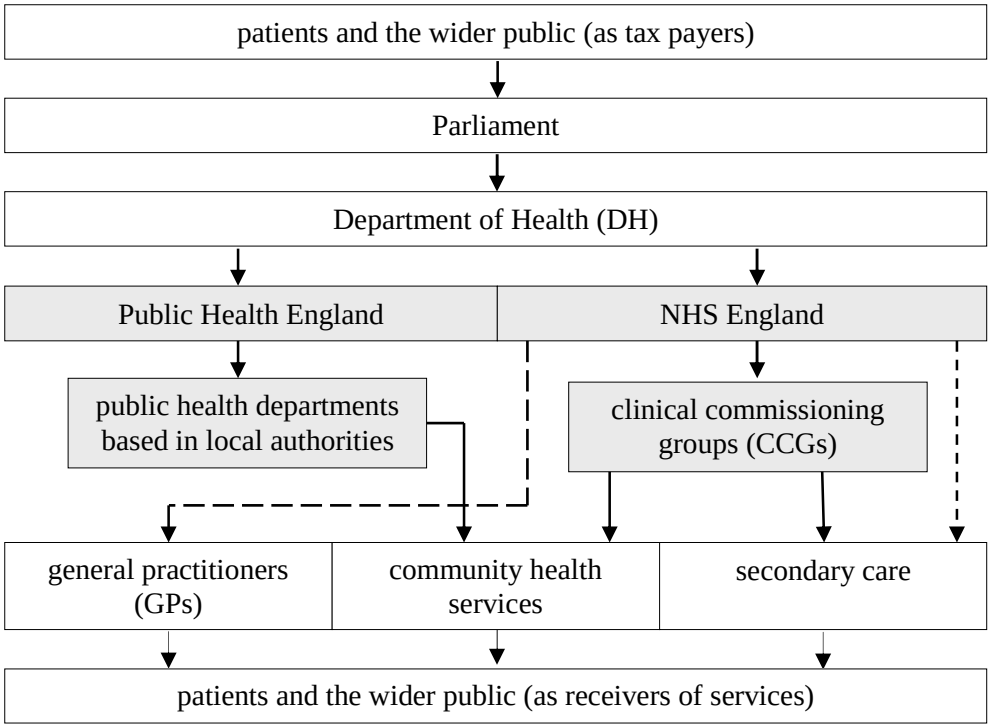

Figure 1: New funding arrangements

Source: Based on The Nuffield Trust (2013).

Legend:
= new organisation
= funding
= service provision
= holds contracts directly
= direct commissioning of specialised services

This article has two purposes. The first is to examine recent changes in healthcare management structures from the perspective of organisational analysis. The second—addressed in the concluding section—is to compare the organisational logic of the new structures with the historical organisational logic of NHS. As the new management system has only been operational since 1 April 2013, the conclusions are based on examination of the Department of Health (DH) proposals, analysed in the light of research into organisational transformations in other sectors—a procedure also used to develop the DH proposals. This article is

concerned with the NHS management structures and processes, not with its overall performance. Research on smaller scale transformations than the radical NHS restructuring showed the difficulty of achieving success, especially in the absence of coherent strategic leadership (Burnes 2000[3]). Substantively, this article argues that the HSCA provisions for the future organisation of NHS are likely to produce the structures and practices characteristic of 'permanently failing organisations'—organisations which survive long-term, but never optimise performance—a concept introduced by the US sociologists Meyer and Zucker (1989), albeit in a different sense. The foremost feature of permanently failing organisations is the pursuit of contradictory objectives, where the achievement of one is necessarily at the cost of another—objectives oppose rather than reinforce one another. Another feature is the lack of fit between the organisation's systems and its institutional ecology—permanently failing organisations seek to operate contrary to the culture and structures of existing organisations in the sector, and run counter to the expectations of the sector's personnel and clients. There are four major grounds for suggesting that the current restructuring of the English healthcare management system will result in permanently failing organisations. First, the HSCA provisions and the structures it establishes seek to achieve incompatible objectives, with incompatibility reflected in the complex allocations of roles and responsibilities. Second, the roles and responsibilities are not clearly defined, resulting from the political compromises necessary to secure the passage of the legislation—organisational arrangements reflect political rather than management considerations. Third, the structures are highly complex, with multiple, overlapping responsibilities. Finally, fourth, the structures do not articulate clearly with professional alignments within NHS, in particular the role of clinical priorities in management.

This article is divided into five sections. Following this initial introduction, the second section discusses the extent to which the objectives of the new system may be reconciled with one another. The third section discusses the clarity of the roles and responsibilities allocated by HSCA, and their overlap. The fourth section identifies the problems of complexity arising from the new structures. The fifth, concluding section returns to the broader question of organisational logic, and the respective roles of the state, markets, independent professionals, medical and state bureaucrats, and patients in the management of the new healthcare system.

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[3] The overview includes a small-scale NHS case study (Burnes 2000: 346–53).

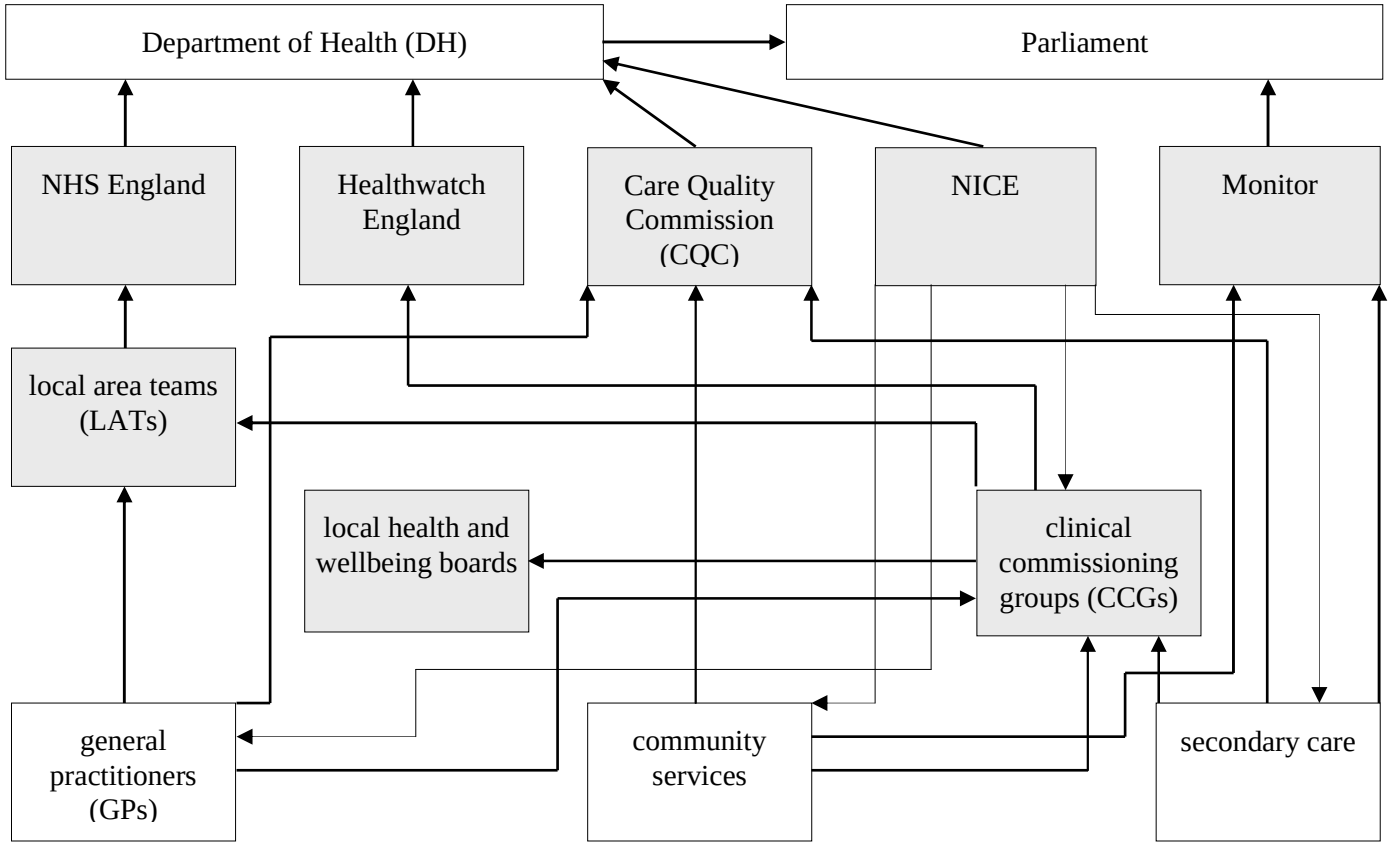

Figure 2: Regulating and monitoring the quality of services
Source: Based on The Nuffield Trust (2013).
Legend: = new or reconfigured organisation; → = accountability; → = advice

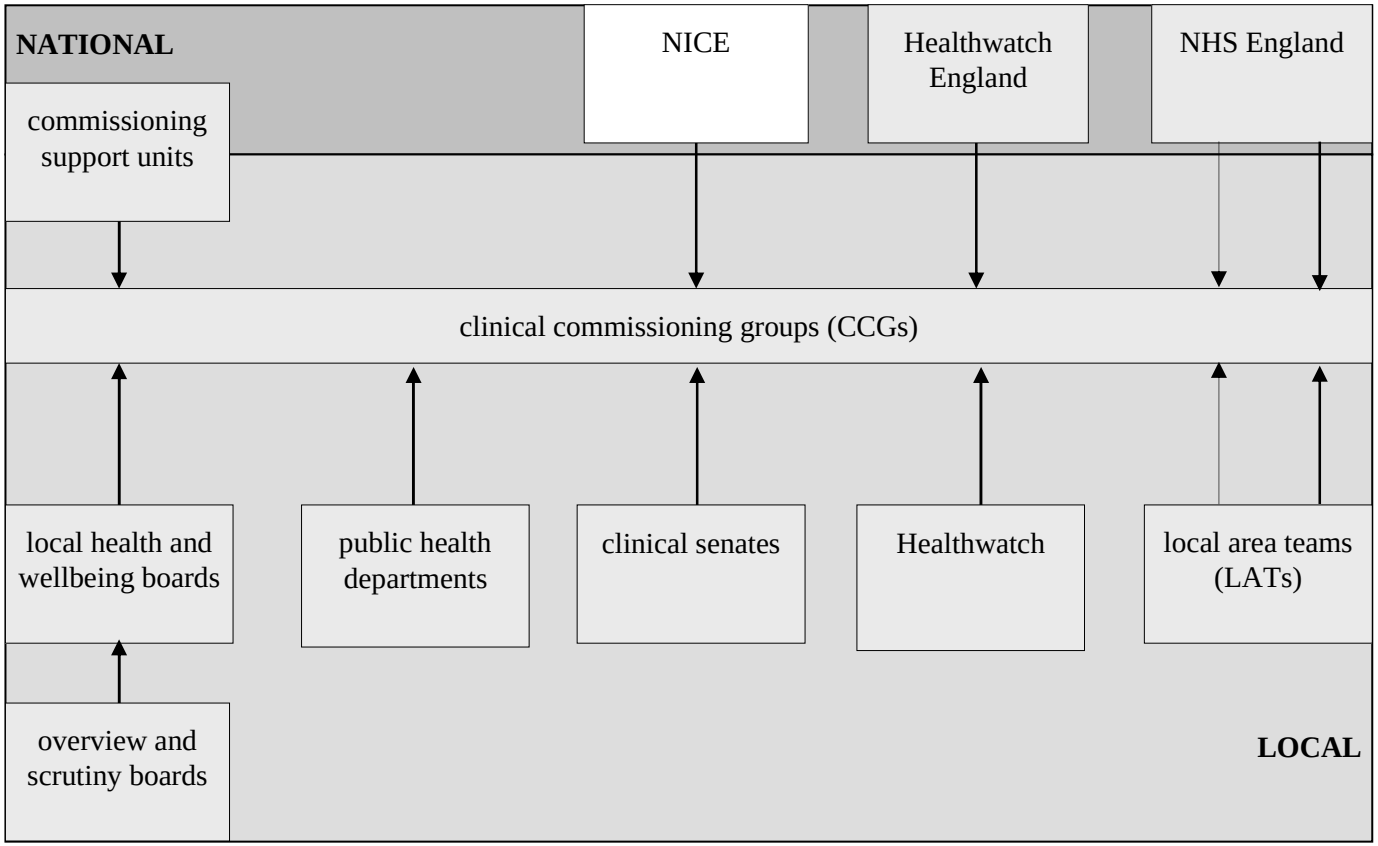

Figure 3: Advice and performance management
Source: Based on The Nuffield Trust (2013).
Legend: = new or reconfigured organisation; → = advice; → = performance management

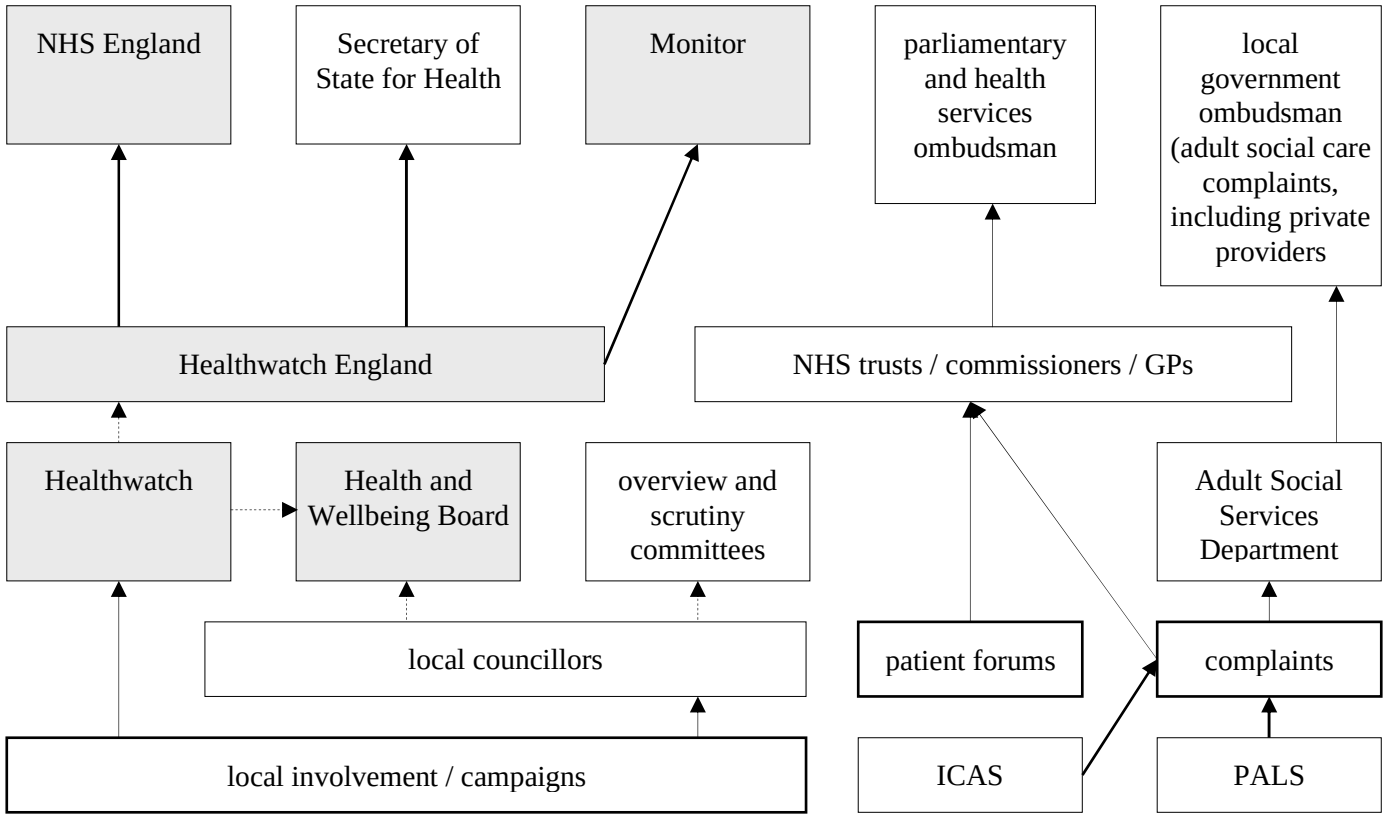

Figure 4: How patients and the wider public can influence their health and social care services
Source: Based on The Nuffield Trust (2013).
Legend: = new or reconfigured organisation; → = support / guidance; → = direct patient involvement; ⇢ = other

Incompatible objectives

The passage of HSCA was highly contentious politically. The Conservative / Liberal Democrat coalition government claimed that HSCA was a continuation and extension of the previous Labour government's policy, which had included contracting out some routine clinical procedures—hip replacement, for example—to the private sector. However, HSCA was strongly opposed by Labour, and by many Liberal Democrats, especially in the House of Lords, Parliament's second chamber. The professional medical associations (including the British Medical Association (BMA), the Royal College of General Practitioners (RCGP), and the Royal College of Nursing (RCN)), the Patients Association, and campaigning organisations like 38 Degrees all lobbied actively against HSCA. Even the Institute of Healthcare Management (IHM) had reservations. Opposition in the House of Lords—spearheaded by Liberal Democrat peers—forced the coalition government to suspend the passage of HSCA through Parliament in 2012. Even after HSCA was passed, the HSCA regulations laid before Parliament in 2013 were challenged in the Lords, forcing further revision. In view of the political compromises that the government was forced to make, it is hardly surprising that HSCA contained conflicting provisions—and paid 'no or perhaps little regard to the administrative and financial burden arising from the [new] regime' (Chatterton 2011). HSCA reflected the parliamentary political context more than the practical difficulties of effectively managing a publicly funded NHS.

The HSCA's five objectives discussed below were (1) raising quality, (2) ensuring patient choice, (3) facilitating innovation, (4) increasing competition, and (5) securing value for money.

(1) Comparative assessments of quality of healthcare provision are difficult to make—and highly controversial, especially for non-professionals. Comparative assessment of hospital performance based on caseload-adjusted death rates—taking account of social, demographic, and economic conditions—provides useful overall measures of quality, but not the fine-grained information required for individual management decisions. National political controversy is easily generated—as over the quality of child heart surgery provided by Leeds General Infirmary and Newcastle General Hospital, for example, even when data on caseload-adjusted death rates became available (Jones 2013). Other widely used measures of quality—such as patient satisfaction surveys—involve subjective judgements reflecting environmental conditions as much as clinical competence. Overall, comparative data on death rates from specific diseases indicate that—pre-2013, and without being outstanding—NHS matched international levels of performance, at relatively low cost (OECD 2012). Decisions designed to raise quality—by raising ward nurse staffing levels and reducing reliance upon nursing assistants, for example—may increase costs, threatening 'value for money' performance.

Moreover, medical judgements of quality might conflict with patient choice, when specialist treatment involves patients in extensive travelling, for example.

(2) Patient choice was given prominence by government spokesmen, although little evidence was provided for its significance for patients. GPs are obliged to provide patients with choice of alternative service providers—but prevented from making recommendations on grounds of ownership. However, patients are ill-placed to make informed judgements, at best relying upon Internet-derived evidence on comparative performance—which does not include the performance of individual consultants—or word of mouth. GPs are naturally reluctant to criticise the performance of their local hospitals—or to run the danger of incurring legal responsibility for advice which subsequently turns out to be wrong. In the absence of relevant knowledge and understanding, meaningful patient choice is impossible—self-diagnosis via the Internet is high risk. Patients consult medical professionals for the kind of professional knowledge and understanding they themselves do not have. Moreover, the objective of patient choice inevitably raises practical difficulties in planning, and is likely to result in increasing costs. The quality of clinical performance is heavily influenced by the level of experience, and the number of operations performed. Improving clinical performance by concentrating operations in a limited number of centres—and thus building up professional experience and skills—is difficult to reconcile with patient choice.

(3) Encouraging innovation was given less prominence than improving quality or enhancing patient choice. Innovation was sought both as a means of reducing costs, through process innovations, and as a means of improving healthcare performance, through developing new products and new services. Market mechanisms are unlikely to result in process innovation in clinical practice, since such innovation often involves cross-functional cooperation, both within and among teams. Such cooperation is easier to achieve with integrated teams in a common organisation than in combinations involving different types of service providers. The DH (2011a) *Impact Assessments for the Health and Social Care Bill 2011*—which accompanied the initial publication of the parliamentary bill—argued that competition would lead to innovation, and, thus, to quality improvement. This may be so in the production of physical products, especially where consumers are able to compare quality effectively, as in motor vehicles or consumer electronics. However, innovation depends upon collaboration as well as competition—and upon high levels of trust among both suppliers and consumers, especially when inputs are difficult to define and outputs difficult to measure. HSCA and the attendant procurement rules may assist in product and service innovation, for example in the introduction of new drugs or new methods of organising, especially to reduce costs.

(4) Increasing competition was a major objective of the management reforms. DH (2011a) stressed the role of competition in enhancing quality of services and

reducing costs, regulation being necessary only where competition failed. Competition was regarded as clearly superior to regulation—'competition where appropriate, regulation where necessary'. The terminology reflected the government's comparison between healthcare and a regulated industry such as telecommunications—where, indeed, competition between suppliers drove technological innovation (Vickers and Yarrow 1988). According to DH (2011a: 34), '[t]here is very clear evidence from across services and countries that competition produces superior outcomes to centralised management and monopoly provision. Competition is more effective where markets are highly contestable and contestability requires that organisations are able to expand / enter the market and contract / exit particular markets in response to consumer preferences.' In support, DH referred to the positive impact of competition on economic performance in the Central and Eastern European post-socialist transitions. Purchasing bodies—such as the clinical commissioning groups (CCGs)—could select without competition when 'satisfied' that the services could be provided by one supplier only—a higher threshold than 'the best provider'. Reflecting the political conflicts, *The National Health Service (Procurement, Patient Choice and Competition) Regulations 2013* underlined that providers must be treated 'equally and in a non-discriminatory way, including by not treating a provider, or type of provider, more favourably than any other provider, in particular on the basis of ownership' (HM Government 2013: 2). Discrimination in favour of NHS providers would open the clinical commissioning groups to legal challenge from unsuccessful private sector bidders, and expensive and time-consuming litigation. A specific service being integrated with other services—with other healthcare services, for example, or with social welfare services—was the major exception.

Legal opinion differed on the implications of the 2013 *Regulations* for the NHS subjection to EU competition law. Neither the British government nor NHS wished NHS to become subject to EU competition law. However, the 2013 *Regulations* were derived from *The Public Contracts Regulations 2006* (HM Government 2006), derived in turn from EU legislation. In particular, competitive tendering was required for any contract above GBP 156,442, with heavy penalties for breaches. Moreover, the EU competition law 'brings under scrutiny any collaborative and collective arrangements and the exercise of dominant local purchasing or providing power' (Cragg 2011: 2), precisely the form of arrangements which had existed within NHS pre-2013. The costs and confusion resulting from any challenge under the EU competition law would be deeply damaging.

For many NHS professionals, the introduction of market principles and competition conflicted with fundamental NHS principles (NHS Support Federation 2012). Differences of principle were reinforced by differences of interest. Controversy over the significance of competition in procurement was partially

driven by the NHS professionals' concerns over creeping privatisation, undermining the financial viability of the service and thus its basic foundations. Private providers could 'cherry-pick' services that were easy to provide, leaving NHS hospitals with only difficult and expensive services, such as acute or accident and emergency, inevitably leading to financial imbalance, or even bankruptcy. Moreover, suppliers competing on price were only able to secure contracts by reducing the costs of labour through lower wages, an obvious threat to the terms and conditions of existing, highly unionised NHS employees.

There is also tension between competition and quality, and between competition and innovation. Assessment of contracts will inevitably focus substantially on price—value for money—a criterion easy to measure, and easy to justify publicly. This may often be at the expense of quality, especially quality of nursing provision, difficult to measure or monitor, as shown by the political controversy over nursing 'compassion' which followed the report into premature deaths at the Mid Staffordshire NHS Foundation Trust (Francis 2013). There is also potential conflict between competition and innovation, where innovation rests upon cross-functional integration and cooperation, difficult to achieve among different types of service providers. Competition also creates difficulties for ensuring continuity in service provision, where private providers have less incentive—and fewer resources—to provide long-term follow-up care. Ensuring continuity in healthcare is more difficult—and more important—than company car after-sale service, for example. Release from hospital raises practical difficulties (over arrangements with social services, for example), whilst postoperative relapses may raise issues of financial responsibility. HSCA proposed measures to facilitate entry into and exit from contracts, for firms facing financial difficulties, for example. However, it is difficult to see how exit could be eased without disrupting continuity of service provision, with serious medical as well as financial consequences. (The financial difficulties of private firms providing social care for the elderly had already resulted in serious financial problems, requiring major financial support from local authorities (Bingham 2013).)

(5) Underlying other objectives, HSCA was concerned to secure value for money, usually interpreted as reducing costs—an urgent objective, in view of the critical state of public finances. The introduction of market principles and the new commissioning arrangements were intended to facilitate control of costs in the medium and long term. Overall expenditure on healthcare increased from GBP 51 billion in 1999–2000 to GBP 102 billion in 2009–10, and GBP 104 billion in 2012–13, and was expected to rise further with a growing—and ageing—population (OECD 2012). Competition between private providers and NHS—and among private providers—would be an obvious means of reducing costs, at least in the short run.

One of the fundamental messages of corporate strategy is the importance of establishing priorities amongst competing strategic objectives, despite the usual difficulty in doing so. Neither HSCA (HM Government 2012) nor the supporting *Regulations* (HM Government 2013) indicated priority among the competing objectives. However, the explanatory note which accompanied the *Regulations*—but which was explicitly excluded from legislation, presumably for political reasons—stated that their purpose was to ensure 'good practice' in procurement, and to protect 'patients' rights to make choices regarding their NHS treatment and to prevent anti-competitive behaviour by commissioners with regard to such services' (HM Government 2013: 8–9). Choice and competition were the priorities—a view shared neither by political opponents, nor by the majority of NHS professionals. Both priorities were underpinned by concern with value for money—the *Impact Assessments* pointed to the overriding purpose of the new management system as aligning clinical and financial responsibility, 'to [create] incentives to ensure commissioning decisions provide value for money and improved quality of care through efficient prescribing and referral patterns' (DH 2011a: 7). The alignment was to be achieved through GPs combining clinical with financial responsibility. The means for linking patient quality of care with patient preference—and efficient prescribing and referral patterns—were not specified. Given the overall financial context—and the supervising role of Monitor—the incentives for GPs to prioritise value for money are difficult to resist.

Lack of clarity in roles and responsibilities

One source of uncertainty and lack of clarity is the relationship between the central government DH and the new NHS Commissioning Board, at the apex of the new management system. The relationship is critical—it reflects the fundamental balance between political and commercial considerations, and the extent to which the NHS Commissioning Board could be insulated from political influence. The initial bill envisaged the transfer of the majority of commissioning responsibilities from DH to the NHS Commissioning Board, funded by a (very large) annual budget allocation. The NHS Commissioning Board was expected to operate on business principles, insulated from political interference. However, this was very strongly opposed by the Labour Party—and by NHS professionals—who argued that it would practically remove commissioning responsibilities from public scrutiny. It is difficult to see how DH could have transferred such a large element of its overall responsibilities to an independent body. The bill envisaged the Secretary of State for Health being accountable for NHS, but not responsible for its day-to-day management. In effect, the bill imposed a self-denying ordinance on the Secretary of State for Health, despite the failure of previous attempts to avoid

political 'interference' in NHS matters. Ministers had not been very good at adhering to self-denying ordinances, especially in the face of constituency pressures, and with possible justifications for action provided by 'accountability', exceptional circumstances, and budgetary responsibilities. Under the original proposals, the Secretary of State for Health would have presented a mandate to Parliament for the forthcoming year, with authority to revise the mandate only in 'exceptional circumstances'. There would have been little possibility for the opposition to question the minister on the performance of the commissioning process. The original proposals would have 'muddied the waters', resulting in marked lack of clarity in the respective roles of Secretary of State for Health and NHS Commissioning Board Chair, and the relationship between them. Following the government's suspension of proceedings on the bill over the summer of 2012, to allow further consultation, the proposal for distancing the Secretary of State for Health from the commissioning process was dropped—the Secretary of State for Health was to remain responsible for the commissioning process and unable to disclaim knowledge. The attempt to reinforce market principles through legislation—by restricting the role of the Secretary of State for Health—was dropped. The issue remains to be resolved in practice.

The issue of institutional arrangements for monitoring quality is confused, with responsibility diffused over several entities (see Figure 2, p. 38, where NICE stands for National Institute for Health and Care Excellence). Overall responsibility for quality rests with the Care Quality Commission, while responsibility for stimulating competition—including the role of competition as a means for improving quality—rests with Monitor. The concerns of the Care Quality Commission differ from Monitor's, and are highly likely to result in conflict. HSCA simply provides that the two should cooperate with each other—there is no mechanism suggested for resolving conflict.

Organisational complexity

The new organisational and funding arrangements are highly complex (see Figure 3, p. 39, where NICE stands for National Institute for Health and Care Excellence), involving both medical and managerial staff in substantial learning processes—the arrangements for public oversight are especially complex. The information technology (IT) systems required to support such structures are also complex—and currently untested.

The relationship between general practices and GP commissioning consortia will be critical to the success of the management reform. General practices will continue to receive direct funding for their patient lists, and for specific services—in connection with public health campaigns, for example, via a special funding

stream. For the purchase of clinical services, general practices will be tied to GP commissioning consortium decisions. GP commissioning consortium performance will be monitored by the Care Quality Commission, for quality, and by Monitor, for competition and value for money. The relationship between general practices and clinical commissioning groups—the extent to which general practices will be bound to follow the clinical commissioning group decisions if patients request an off-list service provider, for example—is unclear. Moreover, not all general practices are represented on their clinical commissioning group. Clinical commissioning groups contain professional managers and accountants, as well as clinically trained personnel. What is the relationship between the two groups? In particular, what influence—formal or informal—do professional managers and accountants exert? Post-2013 clinical commissioning groups may reflect traditional, pre-2013 tensions between clinical and managerial approaches. Finally, where GPs have financial interests in organisations bidding for contracts from their GP commissioning consortia, the new structures may give rise to acute conflicts of interest. Traditional methods of resolving conflicts of interest—by declaring interests and withdrawing from discussions, for example—may be difficult where clinical commissioning groups require inputs from specialised professionals. How effective are the means to control potential conflicts of interest, where medical professionals are involved in organisations competing for contracts?

The number and variety of clinical commissioning group modi operandi raise questions regarding the survival of a national health service. NHS is a national system designed—in principle—to ensure equal quality of healthcare for all citizens. There were already major disparities in healthcare outcomes among regions, before 2013, reflecting regional differences in the lifestyles, economic circumstances, and cultures of patients, as well as differences in quality of provision (ONS 2013). The new structure of 217 clinical commissioning groups—a larger number than initially envisaged—is designed to allow variations according to differences in local need, with budgetary allocations continuing to reflect DH assessments of such local needs. However, attempting to reflect differences in local need—within budgetary constraints—will inevitably lead to what critics have termed ‘postcode lotteries’, with treatments and services available in some—but not all—localities. Operating quality control procedures centrally via the Care Quality Commission (see Figure 4, p. 40, where ICAS stands for Independent Complaints Advocacy Service and PALS for Patient Advice and Liaison Service) will inevitably cut across the localism agenda linked to the clinical commissioning group structures.

The variety of opportunities for patients and the wider public to exercise influence within the new structure suggests that NHS will be subject to extensive oversight. The Healthwatch England committees include healthcare professionals as well as representatives of local authorities, social service organisations, and

patients. However, the extensive array of channels through which influence may be exerted may result in confusion and contradictory pressures—it is unlikely that assessments of quality, made at different levels of the structure, will agree. What pressure the Healthwatch England committees will be able to exert—beyond publicity—is unclear. Moreover, increasing private sector involvement will inevitably result in increasing claims for commercial confidentiality, restricting public access to meaningful data on funding arrangements, the allocation of contracts, and the quality of the services provided. The difficulties in oversight will naturally be greatest over patient complaints.

Monitor is the main mechanism through which DH seeks to implement its commitment to increasing competition. Initially, DH proposed that Monitor should have the responsibility for increasing competition as an end in itself. As a result of very strong opposition, including from healthcare professionals, Monitor's responsibility was reformulated, to expanding competition as a means of improving quality, enhancing innovation, and reducing costs, not as an end in itself. However, the relation between Monitor and other parts of the management system will prove contentious, in view of the continuing strong NHS opposition to Monitor's role in stimulating competition.

The mechanisms for assessing the quality of care are thus complex. Responsibility for quality rests ultimately with the Secretary of State for Health—The Right Honourable Jeremy Hunt, since 4 September 2012. His responsibility is discharged via the independent NHS Commissioning Board, Healthwatch England, regional bodies, and local committees that contain professional representatives, local government representatives, as well as patient representatives. Medical professionals—both hospital consultants and GPs—as well as non-medical staff are thus subject to a broad range of institutional monitoring and assessment procedures, as well as direct patient satisfaction surveys.

Conclusion: management in a permanently failing organisation

Managing healthcare raises in an acute form the relation between politics and public sector management. In the UK, NHS is a central feature of national consciousness, reflected in its prominent role in the London 2012 Olympic Games Opening Ceremony. Policies on NHS were central to the election manifestoes of all political parties in the 2010 General Election, with the Conservative Party promising to protect the NHS budget in real terms—exceptionally, alongside overseas aid and schools—and also to avoid top-down reorganisation. However, the public sector funding crisis that followed the 2008 banking crisis created a funding gap that made reducing public expenditure a priority. The financial crisis provided an opportunity for the Conservative Party to extend marketisation in the

public sector (especially NHS), expand the role of private sector finance, introduce private sector market disciplines, and reduce the entrenched power of professional interest groups. The model was the successful transformation of telecommunications in the early 1980s, which resulted in massively enhanced technological innovation and performance, funded by private investment. Transforming NHS along similar lines would complete the Thatcherite revolution.

Such radical government policies for restructuring the English healthcare management system were strongly opposed by opposition parties, public opinion, and medical and non-medical groups within NHS. HSCA reduces the basic NHS structure to a system of market relations, where patient care is bought by GP commissioning consortia—acting on behalf of general practices—and sold by Any Qualified Providers, within a competitive market. Government policy is designed to create a level playing field for market operations, with improvements in quality, innovation, patient choice, and financial discipline secured through market competition and—ultimately—fear of bankruptcy. Such competition would also drive costs down. In this model, there are strong pressures against inter-organisational collaboration and integration of services, and no role for cross-subsidisation—historically, two prominent features of NHS management. Where private sector providers win contracts, issues of commercial confidentiality arise, inhibiting transparency and accountability. Surprisingly, for a market-driven model, government statements make little mention of profit.

DH's consideration of the HSCA impact focused on a limited range of economic analyses, with little consideration of organisational and operational consequences, except as transitional inconveniences. Operational issues—such as IT system integration—received little consideration. Even in economic terms, there was no consideration of Leibenstein's (1966) 'x-efficiency'. The costs of organisational upheaval associated with the introduction of the new system were recognised as substantial, but regarded as transitional. However, evidence from research on private sector mergers and acquisitions showed that such costs are long term, especially where reconfiguration of IT systems is involved (Burnes 2000)—in the banking sector, for example, where the problems faced by the Co-operative Bank in absorbing the Britannia Building Society delayed the merger. Moreover, the costs of personnel recruitment and training for new management systems are substantial. The redeployment or redundancy of existing staff—and the recruitment and training of new staff—involve heavy costs, whilst the organisational restructuring renders the intellectual capital acquired through previous organisational learning often irrelevant. The supporters of the new healthcare system recognised that market failures occurred—due to externalities, natural monopolies, and imperfect information and uncertainty—but their significance for competition in healthcare provision was neglected, for example in the *Impact Assessments for the Health and Social Care Bill* (DH 2011a).

Permanently failing organisations are characterised by conflicting objectives, where high performance on one criterion generates low performance on another. This is exacerbated where there is no explicit prioritisation amongst objectives. In Meyer and Zucher's study (1989), the emphasis was on the conflicts among countervailing interests which develop within such organisations, which succeed in perpetuating themselves despite low performance. Such pressures exist within NHS, with strong, well-organised interest groups at all levels—amongst medical and nursing staff, as well as manual workers. However, the source of continuing failure is more fundamental, and lies in the conflict between professional commitment—reflected in the priority of clinical considerations, personal qualities such as nursing compassion, and quality of care—and market principles. Professional socialisation for medical staff—with strong orientation towards science and service—is very different from professional socialisation for corporate employees. For example, clinical leaders' reluctance to involve themselves in management concerns was experienced by the author in discussions with NHS staff about developing MBA-type programmes for NHS employees. Moreover, the relation between healthcare employees and patients differs from that between sellers and buyers—under the Hippocratic Oath, doctors ('sellers') are supposed to prioritise the interests of patients ('buyers'), not those of the organisation. Finally, the patient as consumer is not the purchaser, which remains the state—the links between service provision and the patient's financial contribution are indirect.

Governments and commercial organisations have historically had overlapping but distinct roles in healthcare provision in the UK. Governments have historically assumed responsibility for the provision of healthcare, with private sector provision as a peripheral contributor. The continuing role of healthcare as an aspect of social welfare is reflected in the HSCA title—and in the overall attempt to link healthcare with social welfare provision, especially needful for the elderly. However, HSCA shifted the boundaries between the roles of the state and those of private providers in practice, whilst seeking to maintain an element of continuity in rhetoric. The impetus for the shift derived partly from the increased cost of the state-provided service and partly from an ideological view that the role of the state—including its role in welfare provision—should be reduced, with individuals assuming greater responsibility for their own welfare. The Conservative-led coalition government introduced market principles into the provision of healthcare in the belief that markets were the most efficient means of allocating resources. The parallel between providing healthcare and providing consumer goods was explicit—the business practices of the private sector were a means of increasing efficiencies and controlling costs, in the provision of healthcare as in the provision of other services, such as telecommunications and transport. However, consumer attitudes towards healthcare differ from consumer attitudes towards other goods—and even transport—healthcare is more important. Moreover, patients as consumers are

heavily dependent upon the professional judgement and advice of those whom they consult, since they have difficulties in assessing the quality of the service they receive. Since 1948, patient trust has rested upon the absence of a direct financial relationship between patients and GPs, directly threatened by the new system which allocates both medical and financial responsibility to GPs.

Organisations providing healthcare have historically had different cultures and structures from conventional commercial organisations. In particular, healthcare is characterised by the central role of professionalism—amongst medical, nursing, and ancillary staff—institutionalised in the division of labour and reinforced by strong professional and occupational groupings, with associated status differences. Clinical considerations outweigh financial considerations, and clinical status managerial status. The characteristic form of organisation is not the entrepreneurial firm, but Mintzberg's (1979) professional bureaucracy, combining professional commitment with a strong emphasis on rules.

Providing healthcare involves a wide range of stakeholders—the state, commercial enterprises, qualified professionals (both salaried and independent), medical and non-medical managers and bureaucrats, as well as the patients themselves. Managing such a complex system requires recognising the interests of all stakeholders, within an overarching framework of patient needs. The interests of a national health service facing acute financial pressures are not best served by the model of aggressive market competitiveness that characterised financialised capitalism before the financial crisis of 2008. Even major private sector manufacturing organisations—especially in Europe—have rejected the forms of competitive market thinking enshrined in HSCA, as an inadequate basis for long-term competitive advantage (Streeck 2009). Such thinking is even less relevant to publicly funded service organisations, such as NHS. Market competition may stimulate innovation and controlling costs. But it may also lead to lack of investment, lack of long-term perspective, institutional instability, and inadequate learning. It is tragic that such a limited model should be reflected in the new NHS management system, even in a pale form. The HSCA organisational arrangements are a rehash of a market model popular in business schools in the 1990s, applied in a wholly inappropriate context.

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Managing the diffusion of pharmaceutical innovations: conclusions from a literature review[1]

The diffusion of pharmaceutical innovations is a complex process. Its success is crucial for both pharmaceutical companies and patients and is determined by the marketing efforts of pharmaceutical companies, drug characteristics, government policies, and the behaviour of both medical professionals and patients. This article explores the literature on prescribing behaviours for factors influencing new drug uptake in both primary and secondary care. Four quantitatively measurable categories of variables are analysed in terms of prediction of early adoption—prescriber, patient, practice, and drug characteristics. Four major qualitatively accessible categories of variables are also analysed—the perceived attributes of new drugs, the role of professional information sources and evidence, the influence of commercial information sources, and the role of the social system. Although early adoption of new drugs is not a personal trait independent of drug type, early adopters do have some characteristics in common. Understanding the socio-demographic and professional characteristics of early adopters of new drugs—and the interactions among them—might speed up the diffusion process, promote cost-efficient prescribing habits, forecast utilisation, and develop targeted intervention strategies.

In most industrialised countries, drug expenditure as a percentage of the overall healthcare cost is increasing rapidly. Changing demographics—ageing population with increased morbidity[2]—and a rise in the number of drugs per patient contribute obviously to growing prescription costs. However, the key factor in rising drug expenditure is the greater variety and availability of new, expensive drugs and the higher relative cost of pharmaceuticals. The use of new drugs might explain up to 40 per cent of annual increases in expenditure in Canada, while displacement of old drugs with new drugs at higher costs accounts for over 60 per cent of the rise in the UK (Tamblyn et al. 2003; Walley, Mrazek, and Mossialos 2005).

Pharmaceuticals are a research and development (R&D)-intensive industrial sector. Innovation and the successful diffusion of new drugs are critical for the financial performance of pharmaceutical companies—as well as the health of patients. In the UK, the pharmaceutical industry R&D represented 36 per cent of sales in 2009, a level approached by only a small number of defence contractors

[1] This article is based on Lublóy (2012), and the author wishes to thank the AXA Research Fund for the post-doctoral research grant that has enabled the research.

[2] The rate of incidence of a disease.

(ONS 2009). Governments are also major influences, both through regulatory and approval agencies—such as the Food and Drug Administration (FDA) in the US and the National Institute for Clinical Excellence (NICE) in the UK—and through budgetary allocations. The diffusion of innovation is thus determined by the strategies of pharmaceutical companies, by government policies, and by the behaviour of medical professionals. This article concentrates on the last, through a detailed review of the literature on doctors' prescribing patterns. Doctors have to strike a balance between using new drugs—and potentially exposing patients to side effects—and delaying the use of new drugs—and depriving patients of their possible benefits (Jones, Greenfield, and Bradley 2001). The ensuing diffusion process is a complex interaction that reflects attributes of the new drugs as well as characteristics of the potential prescribers and patients. This article analyses the socio-demographic and professional characteristics of early prescribers and users of newly marketed drugs—as compared to majority and late users. It focuses on four quantitatively measurable categories of variables—doctor, patient, practice, and drug characteristics—and differentiates between variables consistently predicting new drug uptake and those producing inconsistent results. This article also analyses the role various information sources and the social network play in the adoption process.

Understanding the mechanisms leading to prescribers' early adoption of new drugs is of major importance for several reasons.

First, it *speeds up diffusion*. Although companies are increasingly innovative and efficient in producing new drugs, the implementation of pharmaceutical innovations is often delayed (Berwick 2003). Where new drugs expand therapeutics in areas of yet unmet clinical need, accelerated adoption benefits both medicine and society—innovative new drugs should be offered fast and homogeneously to the population in need.

Second, it *promotes cost-efficiency*. In many cases, newly marketed drugs only bring a marginal or insignificant contribution to the conventional therapeutic arsenal, often at a substantial cost increase. However, healthcare systems worldwide operate with limited financial resources. Given such budgetary constraints, inappropriate use adversely affects availability of use. When the same pharmacological therapy is available as different brands at different prices, the prescriber selects the new, more expensive brand on socioeconomic constructs rather than medical grounds (Ohlsson, Chaix, and Merlo 2009; also, see pp. 60–75).

Third, it *forecasts utilisation*. Accurate prediction is not only important for pharmaceutical companies, but also for healthcare professionals and policy makers in charge of healthcare budget planning.

Fourth, it *develops targeted detailing and continuing medical education*. Where the adoption of new prescription drugs varies across doctors, there is significant

potential for targeted intervention. Distinguishing between doctors who prescribe new drugs early and those who prescribe them late or never enables targeted intervention through relevant, tailored information—as well as economies of both time and money (Strickland-Hodge and Jepson 1982). Groves et al. (2010) argued that healthcare policy makers should focus on high-volume early prescribers. By virtue of their characteristics—and, possibly, reputation—high-volume early prescribers may have the greatest likelihood of generating peer influence. Detailing and education should promote appropriate use of new drugs, through prescription of the most efficient / least expensive of available alternatives.

This article is structured into five sections. Following this introduction, the second section disputes the doctors' early adoption of new drugs as a personal trait, independent of drug type. The third section presents the research strategy adopted to identify relevant literature. Where early adoption of newly marketed drugs is concerned, research shows considerable variation across prescriber, patient, and practice characteristics. This article differentiates between variables consistently predicting early adoption and those producing inconsistent results. The fourth section analyses characteristics of early adopters and users with the aid of population-based quantitative studies of prescription data and registers. Although they capture the complex realities of prescribing decisions, without survey questionnaires and in-depth interviews, such studies fail to encapsulate the aspects of prescribing decisions comprehensively. To compensate, the fifth section summarises the key findings of the qualitative studies.[3] Finally, the sixth section concludes this article by summarising the research findings and suggesting unexplored questions.

Doctors' early adoption of new drugs—personal characteristic independent of drug type?

Some doctors adopt new drugs early—others adopt them late or never. The implicit assumption is that—irrespective of the drug type—some doctors are more predisposed to adopt new drugs than others. Early adoption behaviour is associated with factors such as the doctor's age and gender, the doctor's personality, and the characteristics of the practice (Coleman, Menzel, and Katz 1959; Williamson 1975b; Strickland-Hodge and Jepson 1982; Weiss et al. 1990;

[3] The qualitative studies referred to in this article are based on data collected through in-depth interviews, focus groups, or survey questionnaires, regardless of data analysis technique, while the quantitative studies referred to in this article are based on prescription data or registers.

Prosser and Walley 2003). Early adopters are believed to influence other doctors' adoption of new drugs significantly.

To identify patterns of early adoption, several recent studies used prescription data in lieu of in-depth interviews, focus groups, or survey questionnaires. Prescription data has the advantage of reflecting the realities of a doctor's practice—including the influences associated with external environments, marketing and regulatory activities, and the nuances of individual patients—as well as the personality and behavioural traits of the doctors (Groves, Flanagan, and MacKinnon 2002).

A rigorous review of the prescription-based literature suggests that 'pure' early prescribers and users do not generally exist—no groups of doctors or patients emerge as prescribers or users of all potentially relevant, newly introduced drugs. Steffensen, Sörensen, and Olesen's (1999) was the first quantitative study to explicitly question the assumption that doctors can be grouped into adopter categories that are likely to share specific characteristics—early adoption was not consistent across drug groups, and the shape and slope of the diffusion curve were dependent on both doctor and drug characteristics. Similarly, Dybdahl et al. (2004) found that general practitioners' adoption of one group of drugs was poorly associated with adoption of others—doctors' early adoption of new drugs was not a personal trait independent of drug type. Two years later, Florentinus et al. (2006) examined the adoption of five drugs by a sample of approximately one hundred general practitioners and identified a small group of innovative general practitioners responsible for a large part of early prescriptions for new drugs. However, the early prescriptions were very much drug dependent—heavy prescribers of one drug were not heavy prescribers of the other four drugs—and varied strongly across general practitioners. Kozyrskyj, Raymond, and Racher (2007) came to similar conclusions.

In contrast, Bourke and Roper (2012) found significant and consistently signed effects with relation to portfolio width across the six drugs under examination—the wider the doctor's prescription portfolio, the shorter the doctor's adoption time. Moreover, where doctors had already adopted one of the six new drugs early, early adoption of one of the other five was significantly faster. However, the argument that doctors with a track record of early adoption generally tend to be early adopters of any new drug was disproved by the sample under scrutiny—none of the doctors adopted all six drugs within six months of their introduction. Besides, out of more than ten, portfolio width was the only variable that consistently predicted early adoption across the six study drugs. Whilst the authors clearly favoured the image of early adopters, their findings rather supported the idea that doctors' early adoption is heavily dependent on the new drugs in question.

To conclude, prescribing data shows inconsistencies in the uptake of study drugs—heavy early prescribers of one new drug may be late prescribers or even

non-prescribers of another. Doctors seem to consider each new drug on its individual merits, and adoption may also be influenced by personal and patient-related characteristics.

The search strategies behind the literature review

The review at the core of this article focuses on literature assessing the prescription of new medicines in both primary and secondary care, with time and geography of no specific interest. In January 2012, several search strategies were run on Google Scholar—each search strategy included at least one keyword from each of the four major categories summarised in Table 1.

Table 1: Summary of keywords for the search strategies

Category	Keywords
object	new drug / new medicine
process	adoption / diffusion / uptake
actor	doctor / general practitioner / physician / specialist
method	population-based / prescribing data / prescription data / registry / quantitative

Since prescription data has the advantage of reflecting the realities of prescribing decisions, only quantitative studies were deemed relevant. Prescription data necessarily includes the influences of sales representatives, advertisement activities of pharmaceutical companies, peer-reviewed journals, scientific meetings, peer pressures, and regulatory environments. Prescription data also reflects individual patient characteristics as well as the personal and behavioural characteristics of the prescribing doctor.

The first 30 records of each search strategy were downloaded and screened for eligibility—thus, of a total of 720 records, 16 studies were included in the review. Their citations were also screened through Google Scholar—and their bibliographies were rigorously checked—to identify further relevant quantitative studies. This process resulted in an additional four studies. The key features of these 20 studies—location and size of sample population, type and number of study drugs, factors that might influence new drug uptake, and methodology—may be summarised as follows. The studies were conducted in developed countries, mostly Northern American and Northern European. The sample populations varied greatly—from 32 healthcare centres to 28,402 general practitioners, for example. The study drugs also covered a wide range—cardiovascular drugs, coxibs, antihypertensives, and antidepressants, for example, with several studies focusing

on more than ten new drugs. The variables under consideration also varied greatly, with some studies focusing only on doctor characteristics, while others also assessed patient, practice, and drug characteristics—their most popular method of analysis was logistic regressions.

There are several possible limitations to this review of the literature. First, it was undertaken by a single reviewer, heightening the potential for errors in the coverage and synthesis of the literature. Second, the search strategies through Google Scholar may have failed to identify quantitative studies where new drug uptake was considered, but not as key focus. Third, quantitative studies have advantages as well as disadvantages. They assess relationships based on huge data sets—however, without specific research questions, outcomes of interest might be completely disregarded, as the structure and content of the data collected by health insurance funds for health insurance purposes may not allow it. Fourth, the interview and questionnaire-based studies reviewed here may have been subject to self-reporting bias—missing independent validation, the quality of their evidence might be suboptimal. Fifth, whether quantitative or qualitative, the studies reviewed here cover a range of drugs, prescribers, geographic regions, and nations—variance in results may simply stem from differences in drugs, prescribers, or locations. In some cases, for example, the lack of concordance among study findings was evidently a straightforward consequence of the different attitudes of general practitioners and specialists. In others, findings were assumed generalisable across prescribers, drugs, patients, and practices.

Factors influencing new drug uptake

In both primary and secondary care, diffusion of pharmaceutical innovations is subject to interacting influences. The idea that early prescribers do not generally exist does not necessarily mean that adoption of new drugs is random. Rather, adoption varies across prescribers, with the prescriber, patient, practice, and drug characteristics summarised in Table 2 (p. 61) and found significant in the adoption process in at least one of the studies. Their number highlights the complexity of pharmaceutical innovation diffusion.

The studies identified several—mostly overlapping—socio-demographic and professional characteristics that prove crucial in the adoption process, and that predict—seemingly consistently—new drug uptake. This article will clearly indicate the characteristics constant across drug types. However, in a number of cases, there is contradiction within the literature. Whilst some studies found one particular variable significant, others found no evidence for the predictive power of that variable. Also, reported correlation between one particular variable and new

drug uptake was not always consistent in terms of direction. These anomalies will also be clearly indicated in this article.

Table 2: Summary of characteristics influencing the diffusion of pharmaceutical innovations

Prescriber Characteristics	**Patient Characteristics**

- gender
- age
- training location
- board certification
- clinical and therapeutic area
- hospital affiliation
- clinical trial participation
- prescribing characteristics
  - total prescribing volume
  - portfolio width
  - prescribing volume of drugs by the same pharmaceutical company as the new drug
  - prescribing volume in the therapeutic class of the new drug
	- age
	- gender
	- socioeconomic characteristics
	  - income
	  - education
	  - health insurance
	- race / ethnicity
	- marital status
	- health

Practice Characteristics	**Drug Characteristics**

- solo / group
- location (urban / rural)
- size
  - number of patients
  - prescribing volume
- number of diagnostic and therapeutic activities
- composition of employees
- private / public
	- medical characteristics
	  - unmet clinical need
	  - suboptimal response to existing therapies
	  - improvement over existing therapies
	  - relative therapeutic / economic advantage
	- safety versus perceived risk
	- perceived efficacy
	- cost
	- marketing budget of the pharmaceutical company

To explain the mechanisms leading to associations between variables and new drug uptake, the findings from the quantitative literature are discussed in conjunction with the most important observations from the qualitative literature—without any claims to comprehensiveness. However, methodological drawbacks render heavy reliance on the qualitative studies problematic. A retrospective study

based on self-report is at risk of recall bias—rather than what actually occurs in practice, surveys and interviews may simply capture normative responses and expressed attitudes. Decision making may involve subconscious factors or factors which prescribers—for whatever reason—choose not to disclose (Prosser and Walley 2006).

Prescriber characteristics

Gender. Gender seems to play an influential role in the early adoption of new drugs—male prescribers are much more likely to adopt new drugs than female prescribers—and the finding seems to be consistent across drug types. In a large-scale quantitative study of British doctors, Inman and Pearce (1993) observed that male doctors had much higher rates of new drug utilisation than female doctors. In the group that prescribed new drugs most heavily, women accounted for only 9 per cent. Later studies came to similar conclusions (Steffensen, Sörensen, and Olesen 1999; Tamblyn et al. 2003; Helin-Salmivaara et al. 2005; Groves et al. 2010). Other studies found that the most likely explanation lies in the difference between the levels of confidence of male and female prescribers with regard to the initiation of new medical treatments to achieve desired health outcomes (Bensing, van den Brink-Muinen, and de Bakker 1993; Tamblyn et al. 2003).

Age. Age also seems to be associated with new drug uptake. Qualitative research suggested unambiguously that early prescribers are younger than the majority (Coleman, Katz, and Menzel 1966; Weiss et al. 1990; M. Y. Peay and E. R. Peay 1994). The quantitative research came to similar conclusions (Tamblyn et al. 2003; Glass and Rosenthal 2004; Groves et al. 2010). Recently, Bourke and Roper (2012) also reported that the age of the general practitioners had a small—but statistically significant—positive effect on time to adoption in four of the six study drugs. Other studies found that the most likely explanation lies with the young doctors' propensity for more aggressive intervention and the older doctors' more established prescribing practices—as well as with targeted marketing practices (Lurie, Rich, and Simpson 1990; Tamblyn et al. 2003). These findings contrast with other studies, some of which found that early prescribers were likely to be older (Kozyrskyj, Raymond, and Racher 2007; Groves et al. 2010) and some of which found no correlation between prescriber age and early adoption of new drugs. However, in general, younger prescribers seem to favour early adoption of new drugs more than older prescribers.

Training location. So far, due to data constraints, only four quantitative studies have assessed the impact of training location on new drug uptake. With the exception of Groves et al. (2010), these studies found that the training location plays an influential role in early adoption of new drugs. From British (Inman and Pearce 1993) and Northern American (Kozyrskyj, Raymond, and Racher 2007)

perspectives, more new drugs are prescribed by doctors with overseas qualifications. At the same time, Tamblyn et al. (2003) found that the generalists and specialists who had graduated from the most recently formed medical school had higher relative rates of new drug use. More likely than not, unmeasured aspects of the training environment influence new drug use in all three studies—basic pharmacological training, policies related to drug detailing, relative financial contribution by the pharmaceutical industry in training and research, or the educationally influential practices of attending doctors during the formative training years (Tamblyn et al. 2003). All in all, the training location does exert a significant influence on new drug uptake.

Board certification. Board certification was found consistently associated with adoption in some qualitative (Weiss et al. 1990) and quantitative (Glass and Rosenthal 2004) studies, but not in others (Majumdar et al. 2001; Corrigan and Glass 2005).

Clinical and therapeutic area. A number of qualitative studies found that doctors are more likely to prescribe new drugs in clinical and therapeutic areas where they feel familiar or have a special interest (Coleman, Katz, and Menzel 1966; Jacoby, Smith, and Eccles 2003; Prosser and Walley 2003; Tobin et al. 2008). In line with these findings, Fendrick, Hirth, and Chernew (1996) reported faster adoption among specialists in secondary care than among generalists in primary care. In contrast, Dybdahl et al. (2011) found no clear association between the general practitioners' self-rated clinical interest and their prescribing of new drugs. Such mixed results were reflected in several quantitative studies. Majumdar et al. (2001), Ruof et al. (2002), Glass and Rosenthal (2004), and Helin-Salmivaara et al. (2005) found that specialists were more likely to adopt new drugs than generalists, while Kozyrskyj, Raymond, and Racher (2007) found mixed evidence. In contrast, Groves et al. (2010) found that generalists were more likely to adopt new drugs than specialists. However, on the whole, the clinical and therapeutic area seems to play a role in the adoption process, with specialists more likely to adopt special-purpose new drugs early and generalists more likely to adopt new drugs used for a spectrum of therapies early.

Hospital affiliation. Hospital affiliation is the subject of many qualitative studies (Strickland-Hodge and Jepson 1988; Feely et al. 1999; Jones, Greenfield, and Bradley 2001; Jones et al. 2001; McGettigan et al. 2001; Prosser, Almond, and Walley 2003; Tobin et al. 2008). Hospital-affiliated doctors are restricted by hospital formularies (Glass and Rosenthal 2004), on the one hand, but exposed to specialist influence, on the other, with specialist influence seemingly outweighing hospital formulary restrictions (Kozyrskyj, Raymond, and Racher 2007).

Clinical trial participation. Clinical trial participation increases early adoption of new drugs according to both qualitative (Denig et al. 1991) and quantitative

(Corrigan and Glass 2005) studies, due to proximity to research and understanding of the evidence base (Chauhan and Mason 2008).

Prescribing characteristics. Prescribing characteristics seem to exert a significant influence on the adoption process. To address the unfulfilled medical needs of some of their patients, doctors with a high patient flow seem particularly alert to new drugs, irrespective of therapeutic novelty (Glass and Rosenthal 2004)—the higher the *total prescribing volume* and the higher the *portfolio width*, the higher the likelihood of early adoption of new drugs. Bourke and Roper (2012) found that such doctors are more aware of alternative options and adopt new drugs early. For First-in-Class[4] drugs, Glass and Rosenthal (2004) found that the higher the *prescribing volume of drugs by the same pharmaceutical company as the new drug*, the higher the doctor's likelihood of early adoption of other drugs from that pharmaceutical company—either due to increased detailing by that pharmaceutical company to the doctor, or to the doctor's confidence and trust in that company / company's sales representatives. For all other new drugs, Glass and Rosenthal (2004) found that the higher the *prescribing volume in the therapeutic class of the new drug*, the higher the likelihood of early adoption of that new drug—new but non-novel drug prescription may be due to pre-existing drugs' failure to fulfil the medical needs of the patients. Non-prescribers in a therapeutic class may not have patients suitable for that therapeutic class, or may not be convinced of that therapeutic class' medical value.

Patient characteristics

Patient characteristics such as age, gender, socioeconomic status, and the presence of comorbidities[5] seem to influence new drug uptake. On the one hand, the empirical evidence is vast—on the other, characteristics of early receivers vary from drug to drug, with the therapeutic goal and the target audience of the drug. An exhaustive review of the relevant literature is therefore impossible.

Age. Doctors' likelihood of continuing to prescribe a particular medication seems to be influenced by patients' age—since elderly patients are more likely to experience side effects, doctors are less likely to prescribe new drugs to older patients (Tamblyn et al. 2003; Álvárez and Hernández 2005) and more likely to prescribe new drugs to younger patients (Mark et al. 2002; Hansen et al. 2004; Greving et al. 2006; Ohlsson, Chaix, and Merlo 2009). Drugs generally designed for the elderly—to treat Alzheimer's disease or arthritis, for example—are of course an exception (Florentinus et al. 2005a, 2005b, 2006; Helin-Salmivaara et al. 2005).

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[4] Pioneering drugs in their respective treatment category.

[5] The presence—or effect—of diseases other than the primary disease of a patient.

Gender. While patient gender might influence the likelihood of starting new medications, new drug characteristics and therapeutic goals usually determine the main gender target group (Mark et al. 2002; Florentinus et al. 2005a, 2005b, 2006; Roer at al. 2010).

Socioeconomic characteristics (*income*, *education*, and *health insurance*). By definition, the socioeconomic status of patients reflects their economic and social position in relation to others, based on income, occupation, and education (Winkleby et al. 1992). An increasing body of registry-based literature suggests that the socioeconomic status of the patient influences doctors' prescribing behaviour irrespective of medical considerations (Mamdani et al. 2002; Roer et al. 2010). High-income patients seem more likely to receive new drugs early (Kozyrskyj, Raymond, and Racher 2007; Ohlsson, Chaix, and Merlo 2009), not least because of their ability to pay for out-of-pocket treatments. Privately insured patients also seem more likely to receive new drugs early (Florentinus et al. 2005a). In addition, elderly patients with a high level of formal education have a higher probability of being dispensed new drugs than those with a low level of formal education, irrespective of gender, age, type of residential area, comorbidity, and number of drugs used (Haider et al. 2008). While the literature is generally homogenous in that patients with high socioeconomic status seem more likely to receive new drugs early, some studies found no association (Hansen et al. 2004).

Race / *ethnicity*. Correlation between race / ethnicity and socioeconomic status suggests correlation between race / ethnicity and new drug uptake. For example, non-African-Americans are more likely to be treated with new medications than African-Americans and Hispanics (Mark et al. 2002; Daumit et al. 2003; Van Dorn et al. 2006; Wang et al. 2006).

Marital status. Marital status might influence new drug uptake, but the pattern varies from drug to drug. Prescription of new-generation antidepressant drugs is more likely among single patients than among married or cohabiting patients (Hansen et al. 2004), for example, whilst prescription of new drugs against high cholesterol is more probable among married or cohabiting patients than among single patients (Ohlsson, Chaix, and Merlo 2009).

Health. A patient's health status—self-reported health, poor response to existing therapies, previous use of certain medications, and presence of comorbidities—evidently plays an influential role in new drug uptake (Florentinus et al. 2005a, 2005b; Greving et al. 2006; Kozyrskyj, Raymond, and Racher 2007). Doctors seem to consider individual contexts seriously, and patient convenience seems to influence new drug uptake and promote earlier adoption among patients in desperate stages.

Practice characteristics

Solo / group. In group / partnership practices, continuous professional stimulation and other social factors seem to accelerate the early adoption of new drugs. Joint responsibility for patients promotes the circulation of medical notes and allows for cross-fertilisation of therapeutic information (Williamson 1975b), while daily personal contact with colleagues provides an efficient channel for information transfer and evaluation.[6] As a result of working closely together, doctors may even become conformist in their prescribing habits (Williamson 1975b).

The empirical literature is ambiguous on the impact of group / partnership practices on new drug uptake. In their classic study, Coleman, Menzel, and Katz (1959) reported that doctors who practice in partnerships introduce new drugs on average 2.3 months earlier than doctors who practice on their own. Williamson (1975b) came to a similar conclusion and demonstrated that the difference in adoption times is a direct consequence of the difference in speed of information evaluation, partially accounted for by contact time with peers. Weiss et al.'s (1990) questionnaire study also concluded that membership in a group practice is a powerful variable in discriminating between doctors who innovate and doctors who do not. One registry-based study supported these findings (Steffensen, Sörensen, and Olesen 1990), while another found the difference disappeared after adjustment for practice size (Dybdahl et al. 2004). The higher the number of patients a practice has, argued Dybdahl et al. (2004), the higher the probability to consult a patient who might be a candidate for a new drug—a conclusion Steffensen, Sörensen, and Olesen (1990) may have drawn too, had they adjusted for practice size. M. Y. Peay and E. R. Peay (1988, 1994) did not support the contention that doctors practising in partnership differ from their solo counterparts. Furthermore, Florentinus et al. (2006) found that doctors who practise on their own prescribe more new drugs than those in group practices, possibly because such doctors interact with specialists much more than with other generalists, and because hospital consultants have much more influence over the adoption process (M. Y. Peay and E. R. Peay 1994; Prosser, Almond, and Walley 2003). Adjusting for practice size is essential in determining whether early adoption of new drugs stems from high number of patients or from continuous professional stimulation. Previous empirical research rather suggests the former contention—group practices adopt new drugs early because they are (much more) likely to meet patients in need of the new drugs.

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[6] For a discussion of the role of social networks in the early adoption of new drugs, see pp. 74–5.

Location (urban / rural). Urban practice locations might result in early new drug adoption, while late new drug adoption in rural areas might be due to the personal characteristics of doctors who elect to practice in rural communities. Besides, in contrast with their urban colleagues, rural doctors have fewer opportunities for professional interactions with peers, an important factor in the decision to initiate new treatments (Coleman, Menzel, and Katz 1959; Williamson 1975b; M. Y. Peay and E. R. Peay 1994; Jones, Greenfield, and Bradley 2001; McGettigan et al. 2001). The lower utilisation rates might also be explained by the differential intensity of visits by pharmaceutical industry representatives related to geographic inaccessibility (Tamblyn et al. 2003). According to a questionnaire study, rural doctors are less likely to prescribe new drugs than their urban colleagues (Cutts and Tett 2003)—the prescribing data reflected doctors' self-reported behaviour (Tamblyn et al. 2003; Bourke and Roper 2012). Groves et al. (2010) also found that the upper quartile of high-relative doctors might be best classified as doctors with urban practices. In contrast, the mail survey of Buban, Link, and Doucette (2001) found no apparent influence of location on oncologists' adoption of a new agent, suggesting a reassuring efficiency of information dissemination. Four other quantitative studies also found no support for the early new drug adoption of urban areas (Majumdar et al. 2001; Álvárez and Hernández 2005; Behan, Cutts, and Tett 2005; Ohlsson, Chaix, and Merlo 2009). Moreover, at the other extreme, Groves et al. (2010) found that doctors classified as high-total new drug prescribers were more likely operating in rural areas, possibly due to high patient and elderly patient loads.

In sum, the majority of the studies indicated effective methods of information dissemination across geographical boundaries (Majumdar et al. 2001; Álvárez and Hernández 2005; Behan, Cutts, and Tett 2005; Ohlsson, Chaix, and Merlo 2009; Groves et al. 2010). Modern communication technology most probably enables rural doctors to be as up-to-date as urban doctors—with abundant possibilities for continuing education and exchanges with colleagues, and with full access to information from pharmaceutical companies.

Size (*number of patients* and *prescribing volume*). Number of patients is one potential measure of the size of the practice, and of the likelihood to adopt new drugs early—the higher the number of patients, the higher the likelihood (Strickland-Hodge and Jepson 1982; Weiss et al. 1990). Some quantitative studies supported these observations (Steffensen, Sörensen, and Olesen 1999), others did not (Álvárez and Hernández 2005). Strickland-Hodge and Jepson (1982) offered three explanations for the association between patient list size and new drug uptake. First, the higher the number of patients, the higher the probability of patients with conditions targeted by the new drugs. Second, the more innovative a doctor is perceived, the higher the doctor's likelihood to attract patients. Third, doctors busy with patient management do not have time for critical evaluation of

advertisements and take favourable drug information for granted. At practice level, no association was found between high prescribing volume and early adoption of new drugs (Glass and Rosenthal 2004; Ohlsson, Chaix, and Merlo 2009). Similarly, Dybdahl et al. (2005) found few, weak, and inconsistent associations between early adoption of new drugs and previous prescribing of drugs belonging to the same therapeutic class. Whether measured by number of patients or prescribing volume, the size of the practice does not play an influential role in the early adoption of new drugs. This conclusion is not only counterintuitive, but also at odds with individual doctor's prescribing characteristics (see pp. 62–4). However, the innovative and conservative behaviours of the individual doctors may only cancel one another out, when summed up at practice level.

Number of diagnostic and therapeutic activities. Steffensen, Sörensen, and Olesen (1999) and Álvárez and Hernández (2005) found that a high volume of diagnostic and therapeutic activity is associated positively with early adoption of new drugs—at least for generalists, if not for specialists (Tamblyn et al. 2003). A high volume of diagnostic and therapeutic activity may be indicative of the severity of the patients' health, and of the need for early adoption of new drugs

Composition of employees. Ohlsson, Chaix, and Merlo (2009) found that healthcare practices employing specialists as well as generalists are more likely to adopt new drugs early than practices employing generalists only. Bourke and Roper (2012) found similar results for practices employing the assistance of a nurse or secretary.

Private / public. Ohlsson, Chaix, and Merlo (2009) found that private healthcare practices are more likely to adopt new drugs early than public healthcare practices.

Drug characteristics

The majority of drug characteristics—the suboptimal response of patients to existing therapies and the safety and perceived efficacy of new drugs, for example—can be measured only qualitatively. The two drug characteristics measurable quantitatively are the cost of a new drug and the marketing budget of the pharmaceutical company introducing it.

Medical characteristics. Unmet clinical need, suboptimal response to existing therapy (Jones, Greenfield and Bradley 2001; Prosser and Walley 2003), *improvement over existing therapies* (Jones, Greenfield and Bradley 2001; Prosser and Walley 2003), and *relative advantage—therapeutic* or *economic*—over existing therapies all influence the early adoption of new drugs.

Safety versus perceived risk. Safety—including adverse side effects and interactions with other drugs prescribed to the patient—is the primary concern in early adoption of new drugs (Ruof et al. 2002; Mason 2008; Tobin et al. 2008),

while Williamson (1975a), Jones et al. (2000), and Jones, Greenfield, and Bradley (2001) stressed the impact of the perceived risk. In general, the higher the risk, the longer the average early adoption time. However, M. Y. Peay and E. R. Peay (1994) found that highest-risk drugs are adopted fastest, suggesting that the doctors' tolerance of risk depends on the severity of the illness.

Perceived efficacy. The higher the perceived efficacy, the higher the early adoption of new drugs (M. Y. Peay and E. R. Peay 1988; Jones et al. 2000; Buban, Link, and Doucette 2001; Jones, Greenfield, and Bradley 2001; Groves, Flanagan, and MacKinnon 2002; Ruof et al. 2002; Jacoby, Smith, and Eccles 2003; Prosser and Walley 2003; Greving et al. 2006; Tobin et al. 2008).

Cost. Although cost is a quantitatively measurable variable, no study has analysed systematically the influence of the relative price on the early adoption of new drugs. In general, cost is less important than both safety and perceived efficacy (Chauhan and Mason 2008), and does not represent a significant barrier in the early adoption of new drugs (Mason 2008). Doctors try to balance efficacy and cost, but they are not reluctant to prescribe higher cost, more effective drugs (Jones, Greenfield, and Bradley 2001; Prosser and Walley 2003; Tobin et al. 2008). Jacoby, Smith, and Eccles (2003) found that the most frequent early adopters of new drugs are the least cost conscious. However, in general, doctors feel high-cost new drugs constrain their routine prescribing to cases where the cheaper alternatives were either not tolerated or ineffective (Booth-Clibborn, Packer, and Stevens 2000; Ruof et al. 2002; Prosser and Walley 2003).

Marketing budget of the pharmaceutical company. The marketing budget of the pharmaceutical company put behind the new drug influences early adoption (Glass and Rosenthal 2004; Booth-Clibborn, Packer, and Stevens 2000). However, neither the qualitative study of Jones, Greenfield and Bradley (1999) nor the quantitative study of Tamblyn et al. (2003) identified a relation between advertising intensity and early adoption of new drugs. Thus, per se, the marketing budget does not influence early adoption of new drugs. However, the marketing budget specifically assigned to a new drug does exert a significant, consistently signed influence (Glass and Rosenthal 2004).

Other factors

Early adoption of new drugs occurs in complex environments, subject to numerous influences. A substantial amount of qualitative research has addressed the channels of information concerning new drugs and the factors that influence

individual doctors' early adoption.[7] The list of factors reviewed herewith is comprehensive, even if the review itself is far from comprehensive. Doctors may become aware of new drugs from commercial sources, while the ultimate sanction to prescribe may stem from professional sources such as medical journals (Strickland-Hodge and Jepson 1980). This section focuses on the role these various sources of information play and discusses the role of the social network by highlighting the influence of interpersonal communication on early adoption.

General practitioners and specialists differ in the extent to which they use various information sources (Jones, Greenfield, and Bradley 2001; McGettigan et al. 2001). Objective sources of information—journal articles and evidence-based information from independent organisations, for example—seem underutilised by general practitioners (M. Y. Peay and E. R. Peay 1988, 1994; Jones, Greenfield, and Bradley 2001; McGettigan et al. 2001; Tobin et al. 2008). Instead, general practitioners rely on the commercial information provided by pharmaceutical companies through sales representatives. Prosser, Almond, and Walley (2003) described general practitioners as largely reactive and opportunistic recipients of new drug information, rarely undertaking an active information search. In contrast, specialists are close to new drug development and likely to be aware of new drugs before their official approval (M. Y. Peay and E. R. Peay 1994). For them, colleagues—from their own speciality or from other specialities—and clinical meetings are of greatest practical importance. Marked differences in the working environments of the two groups of prescribers may explain these behavioural differences (McGettigan et al. 2001). General practitioners work often alone—or with just a few colleagues—for them, sales representatives and consultants may represent the main channel to exchange professional ideas. In contrast, specialists work in hospital settings—for them, regular interactions with peers facilitate the diffusion of ideas and innovations.

Professional information and evidence

A drug launch is accompanied by a large volume of information, both commercial and professional. Doctors for whom drug safety and efficacy are paramount rely on established, scientific, non-commercial evidence—in general, specialists represent the subgroup of doctors who rate independent research as the key source of empirical validation for new drugs (Jones et al. 2000; Jones, Greenfield, and Bradley 2001; Prosser and Walley 2006).

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[7] Interviews and questionnaire surveys rely on the doctors' subjective recalls of prescribing events, possibly prejudiced by social desirability bias. This is a caveat worth remembering in interpreting the results, especially since sources considered important in theory are not of greatest practical utility (McGettigan et al. 2001).

Many research studies highlighted the role *peer-reviewed journals* play as sources of information on new drugs (Coleman, Menzel, and Katz 1959; M. Y. Peay and E. R. Peay 1990; Jones, Greenfield, and Bradley 2001; McGettigan et al. 2001; Jacoby, Smith, and Eccles 2003). Sometimes, specialists even ask sales representatives to provide information from the scientific literature (Jones, Greenfield, and Bradley 2001), journal articles on *randomised clinical trial*s and *meta-analysis* being judged the best (Prosser and Walley 2006). In both primary and secondary care, sound research evidence was reported to be very influential in reaching prescribing decisions (Coleman, Menzel, and Katz 1959; Jones et al. 2000; Jacoby, Smith, and Eccles 2003). However, some researchers contested the value of peer-reviewed journals, considered excessively time consuming, out of date, and overly complex by some doctors (Prosser and Walley 2003).

Several studies indicated that *drug bulletins* represent an important channel of information about new drugs (McGettigan et al. 2001; Groves, Flanagan, and MacKinnon 2002)—in theory, general practitioners most frequently rate drug bulletins together with medical journals as important (McGettigan et al. 2001).

Specialist meetings, *presentations*, *conferences*, and *symposia* provide a highly valued source of information, facilitate interaction among doctors, and may influence the early adoption of new drugs (Coleman, Menzel, and Katz 1959; Buban, Link, and Doucette 2001; Jones, Greenfield, and Bradley 2001)—early information might act as a catalyst for early awareness and positive evaluation, through interactions with professionals at national and international events (M. Y. Peay and E. R. Peay 1994). . Most probably, doctors more sensitive to new developments attend more such forums, although attendance may be expensive (Groves, Flanagan, and MacKinnon 2002).

Some degree of *association with an academic centre*—through teaching, publishing, or holding an academic appointment, for example—shows a heightened professional orientation and results in early adoption of new drugs (Weiss et al. 1990).

Guidelines, *hospital formularies*, and *protocols* might also exert influence on new drug uptake. In theory, specialists consider the national formulary as the second most important source of information on new drugs, senior colleagues being the first (McGettigan et al. 2001). In practice, Wathen and Dean (2004) found that best practice guidelines have little impact on new drug uptake in the UK. Nevertheless, technological guidelines accompanied by other sources of information or personal experience trigger an increase in prescribing new drugs. Of course, new drug uptake might be constrained as well as facilitated by guidelines, hospital formularies, and protocols (Prosser and Walley 2006). Similarly to *government policy* (Griffin 1995), guidelines might promote therapeutically innovative, cost-effective new drugs, whilst prohibiting expensive

new drugs (Jones et al. 2000). (However, specialists can overcome formulary restrictions by recommending new drugs to general practitioners.)

Prescribing decision support systems provide evidence-based recommendations and help doctors identify patients who might benefit from pharmaceutical innovations. They may increase the early adoption of therapeutically advanced, cost-efficient new drugs—general practitioners who use them are less inclined to prescribe cost-inefficient new drugs (Greving et al. 2006).

Finally, *personal experience* has a high impact on doctors' prescribing behaviour (Buban, Link, and Doucette 2001; Jones, Greenfield, and Bradley 2001; Prosser, Almond, and Walley 2003). Individual trialling might be urged by exhaustion of other possibilities, by the doctors' personal curiosity, or by patients. Trialling is essentially a reflective process that allows doctors to test therapeutic outcomes and interpret evidence in the light of experience (Prosser and Walley 2006)—positive experiences with a new drug induce changes in prescribing behaviour, while negative experiences most likely lead to the rejection of the new drug.

Commercial information

Although they place more emphasis on professional information, specialists might rely on commercial information for drugs outside their speciality. In contrast, general practitioners indicate greater preference for commercial information—time constraints and the broader range of conditions they treat do not allow general practitioners to review satisfactorily all relevant professional information. However, for both specialists and generalists, information from sales representatives is often the first source of information.

The commercial information is provided by pharmaceutical companies. Pharmaceutical companies aim to boost profits by incorporating new drugs early in their lifecycle, by raising awareness among top professionals, and by maintaining the new drugs' first-choice statuses within their respective therapeutic groups (Groves, Flanagan, and MacKinnon 2002). Pharmaceutical marketing not only raises awareness—it evidently influences decision making too.

The prominence of *commercial information* in early adoption of new drugs was shown—for example—by Avorn, Chen, and Hartley (1982), M. Y. Peay and E. R. Peay (1988), and Prosser, Almond, and Walley (2003). Interactions with *sales representatives* have a particularly strong impact (M. Y. Peay and E. R. Peay 1988, 1994; McGettigan et al. 2001; Jones, Greenfield, and Bradley 2001; Jacoby, Smith, and Eccles 2003; Prosser, Almond, and Walley 2003; Tobin et al. 2008)—early prescribers use sales representative information intensively (Jones, Greenfield, and Bradley 2001; Prosser, Almond, and Walley 2003; Tobin et al. 2008). Three-quarters of US doctors consider pharmaceutical marketing information useful

(Kaiser Family Foundation 2002). In general, sales representatives are viewed as an expedient means of keeping up-to-date and acquiring and processing drug information—even when doctors intend to minimise the importance of sales representatives, to avoid distorted, selective, and overly positive information (Prosser, Almond, and Walley 2003; Chauhan and Mason 2008).

Pharmaceutical companies facilitate new drug awareness in many other ways, including through *direct mail*, *conferences*, and *journal advertisements*—in peer-reviewed medical journals, controlled-circulation journals, or pharmaceutical prescribing reference guides (Strickland-Hodge and Jepson 1982; M. Y. Peay and E. R. Peay 1994)—or through *sponsoring of continuing education* and *funding of clinical trials*.

If allowed, *direct-to-consumer advertising* in the mass media influences early adoption of new drugs through patient requests. Promoting the potential benefits of new medications may stimulate unmet demand to treat certain conditions or may raise expectations of better relief than available products—empirical evidence showed that the percentage of patients who had requested a treatment for which they had sought outside information was positively associated with early adoption of new drugs (Buban, Link, and Doucette 2001). The role of patients should therefore not be underestimated, especially since general practitioners report that patients often request new medications—time constraints and the desire to avoid conflict and increase patient role in decision making being quoted as reasons for granting them (Prosser, Almond, and Walley 2003). However, Chauhan and Mason (2008) reported little evidence of patients influencing prescribing decisions, but forecasted increasing patient impact on new drug uptake, as self-care and patient-choice agendas gain increasing prominence. Whether direct-to-consumer advertising is actually effective in getting doctors to write prescriptions is still a matter for debate in the literature (Glass and Rosenthal 2004).

Finally, pharmaceutical *samples* influence new drug uptake, since doctors who receive new drug samples are more likely to adopt it than the others (M. Y. Peay and E. R. Peay 1988).

In sum, pharmaceutical companies provide knowledge, increase product awareness, and direct further information acquisition—they have a direct impact on prescribing. In an environment of growing emphasis on evidence-based medicine, does professional information counterbalance commercial information? Greving et al. (2006) found that general practitioners who rely on commercial information are more likely to prescribe new drugs in preference to other drugs from the same therapeutic class. Promotional information—they concluded—continues to determine the early adoption of a new therapeutic class.

Communication among professionals

A wide variety of research showed that *interpersonal communication* between opinion-leading doctors and their peers is a critical factor in the rapid, wide-scale acceptance of innovative drugs (Coleman, Menzel, and Katz 1959; Williamson 1975b; M. Y. Peay and E. R. Peay 1994; Jones, Greenfield, and Bradley 2001; McGettigan et al. 2001). Personal contacts provide a real stimulus, since key opinion leaders present reliable, easy-to-digest assessments of new drugs. While other sources of information provide the nurturing groundwork of necessary knowledge, behavioural change requires the legitimising power of personal advice from informed and respected colleagues (Weiss et al. 1990).

Coleman, Menzel, and Katz (1959) argued that the *network of informal relations* among doctors is highly effective in transferring information and influencing the diffusion of pharmaceutical innovations—socially integrated doctors introduce new drugs quicker than their more isolated colleagues. The finding was found valid for all three social structures of the medical community studied (advisor, discussion, and friend networks), with one caveat—the channels of influence among doctors operate most powerfully during the first few months after the release of a new drug.

A significant amount of literature addressed the *influence of specialists on their specialist colleagues* (Weiss et al. 1990; M. Y. Peay and E. R. Peay 1994; Buban, Link, and Doucette 2001; Jones, Greenfield, and Bradley 2001; McGettigan et al. 2001). Consultants rely heavily on the advice of colleagues regarding the utility of new medications (Weiss et al. 1990; Jones, Greenfield, and Bradley 2001)—they rate their senior colleagues most frequently as important for new drug uptake (McGettigan et al. 2001). In both theory and practice, the number of contacts with other doctors is the most consistent predictor of early awareness and prescription (M. Y. Peay and E. R. Peay 1994). However, although doctors who serve as information sources for colleagues (whether as sources of advice or recipients of referrals) learn about a new drug earlier, they do not prescribe the drug earlier. In contrast, doctors defined as information seekers (whether as seekers of drug advice, sources of referrals, or conference attendees) are not only aware of a new drug earlier, but also prescribe it earlier (M. Y. Peay and E. R. Peay 1994).

Composition matters too, not just the number of contacts. Beside the number of specialist colleagues inside the main practice setting, interactions with specialist colleagues outside are also significantly associated with new drug uptake (Weiss et al. 1990; Buban, Link, and Doucette 2001)—informal communication channels outside the main practice setting raise the likelihood of learning about therapeutic advances.

Local opinion leaders play a particularly influential role in the diffusion of pharmaceutical innovations (Greer 1988; Soumerai et al. 1998). Their evaluations form the basis for consensus among their groups—a prerequisite for diffusion.

A vast amount of literature emphasised the *influence of specialists on new drug uptake in general practice*, through *advice* or *example* (Strickland-Hodge and Jepson 1988; Feely et al. 1999; Jones, Greenfield, and Bradley 2001; Jones et al. 2001; McGettigan et al. 2001; Prosser, Almond, and Walley 2003; Tobin et al. 2008). A significant amount of general practice prescribing is hospital-initiated or hospital-led (Jones et al. 2000; Jacoby, Smith, and Eccles 2003). New drugs seem to diffuse into general practice through a two-step process, with hospital consultants as innovators and general practitioners as followers, with perceived uncertainty of new drug prescription thus significantly reduced (Prosser and Walley 2003). However, Florentinus et al. (2009) found no supporting evidence for this model—general practitioners are responsible for a considerable amount of early prescription of new drugs.

Consistency of evidence reduces uncertainty and promotes new drug uptake (Prosser and Walley 2006). Perceived *local consensus* and *conformism* with consultants—or other respected professionals—or with other group norms is also likely to shape prescribing behaviour (Jacoby, Smith, and Eccles 2003). In contrast, lack of consensus over best use slows down the diffusion of pharmaceutical innovations (Chauhan and Mason 2008).

Finally, *doctors who sit on decision-making bodies*—such as the drug and therapeutic committees (DTCs) in the UK, for example, which evaluate drugs for introduction in formularies—appear to have a special influence, due to proximity to research and understanding of evidence base (Chauhan and Mason 2008).

Summary and discussion

For patients to receive the best possible care, doctors have to consider the risks and benefits of new drugs in conjunction with patient characteristics. However, healthcare budget limitations cannot be ignored—initiating treatment for one patient adversely affects therapy availability for other patients. Efficient prescribing is a complex exercise, and early adoption of new drugs is the outcome of interactions among prescriber, patient, drug, and the interpretation of evidence. The determinants of the decision to prescribe are interconnected in many—often conflicting—ways. However, a rigorous review of the literature revealed a number of variables that produce consistent prediction of early adopters.

At prescriber level, male general practitioners typically prescribe new drugs earlier than female general practitioners. Foreign qualifications and graduation from most recently formed medical schools are also associated with higher rates of

new drug use. Similarly, interest in particular clinical or therapeutic areas also exerts influence on new drug uptake. Early adoption of special-purpose drugs is more likely among specialists than among generalists, while drugs used for a wide spectrum of therapies diffuse faster among general practitioners. Partly related to clinical interest, clinical trial participation is also a powerful predictor of early adoption. Finally, prescribing habits exert a significant influence on the adoption process. Not surprisingly, the greater the number of total prescriptions written for all types of drugs and the wider the prescribing portfolio, the greater the chances of writing prescriptions for new drugs.

At patient level, consistent predictors of new drug uptake include young age and high socioeconomic status—high income, high level of formal education, and being member of the majority race / ethnicity of the country. Furthermore, poor health status—either self-reported or due to comorbidities or unsatisfactory response to existing therapies—also promotes new drug uptake.

At practice level, the volume of diagnostic and therapeutic activity is consistently associated with new drug utilisation—the higher the number of healthcare services delivered, the more severe the health status of the patients is likely to be, urging adoption of new drugs.

Most drug characteristics can only be measured qualitatively, through in-depth interviews and survey questionnaires. One exception is the marketing budget a pharmaceutical company puts behind a new drug. In line with expectations, the higher the marketing budget, the faster the adoption.

However, categorising early and late prescribers for a number of other variables is not possible, due to inconsistent results.

At prescriber level, the age of the doctor is a debated characteristic—in the majority of cases, no association was found. Where association was found, young age favoured early adoption, in line with intuition. At the same time, neither board certification nor hospital affiliation associates consistently with new drug uptake.

At patient level, characteristics of early receivers vary from drug to drug, mostly depending on the therapeutic goal and the target audience of the drug. In line with this, neither the gender nor the marital status of the patient produces consistent prediction. However, of course, old age favours adoption of drugs designed specifically for the elderly.

At practice level, several variables yielded inconsistent results in quantifying the likelihood of new drug uptake. Group practices associate with new drug uptake in some studies—most probably due to high numbers of patients in need of such therapies rather than professional stimulation from colleagues—but not in all. Practice location (rural or urban) also does not predict consistently new drug uptake. Drug-related information and marketing activity have good reach across geographic areas—the immediate demand for new drugs is stimulated to a similar extent in both urban and rural areas. Practice size—measured either by number of

patients or prescribing volume—also does not associate consistently with new drug utilisation. Presumably, the innovative and conservative behaviours of the individual doctors can only cancel one another out, when summed up at practice level.

Prescribing decisions cannot be captured without in-depth interviews and survey questionnaires—the list of factors identified in the previous section was comprehensive, even if the review itself was not. A new drug launch is accompanied by a large volume of information. In general, to judge drug safety and efficacy, specialists place emphasis on established, professional information, while general practitioners rely more upon commercial information. Pharmaceutical companies disseminate commercial information and provide knowledge, increase product awareness, and direct further information acquisition.

Integration—professional and social—appears to be an important influencing factor, with information relayed through direct, personal contacts proving particularly powerful in new drug uptake (Coleman, Menzel, and Katz 1959; Greer 1988; M. Y. Peay and E. R. Peay 1994; Weiss et al. 1990; Jones, Greenfield, and Bradley 2001; McGettigan et al. 2001; Tobin et al. 2008). Specialist peers are the most powerful contacts among hospital consultants, while both sales representatives and hospital consultants drive new drug uptake among general practitioners. This possibly richest medium of communication—and of influence over new drug uptake—has important implications for both pharmaceutical companies and healthcare strategists. Pharmaceutical companies should continue to devote significant proportions of their marketing budgets to sales representatives, and should target customised and scientifically valuable information at key opinion leaders. At the same time, healthcare strategists should be very careful with projects that rely on electronic databases—efforts to utilise objective information to improve prescribing had ambiguous outcomes (Chauhan and Mason 2008), and healthcare strategists should preferably rely on specialists to systematically disseminate new drug information and prescribing guidelines.

This article has shown that early adoption of new drugs is an extremely complex process. The diffusion of pharmaceutical innovation is the outcome of interactions among doctors' prescribing behaviours, doctors' social networks, and pharmaceutical companies' product strategies, within healthcare institutional settings—outside the US—established largely by governments. Due to data constraints, only Glass and Rosenthal (2004) controlled for the impact of pharmaceutical marketing on early adoption of new drugs. However, their product strategy variable was an aggregate reflecting the size of the marketing budget, not a prescriber demographic or a practice characteristic—an issue for examination by future research.

Doctors' individual characteristics and social interactions are of particular importance in their prescribing behaviour, principally among specialists. Predicting doctors' prescribing behaviour is a complex and multifactoral exercise in itself—just as much a challenge for research in the future as it has been in the past. So far, researchers have failed to make accurate and consistent predictions regarding doctors' early adoption of new drugs. Henceforth, research into early adoption of new drugs should most probably be directed not only towards the specific characteristics of doctors, patients, pharmaceutical companies, and the drugs themselves, but also towards the interactions among characteristics and social networks. To this end, Iyengar, Van den Bulte, and Valente (2011) carried out pioneering research by combining individual-level new drug adoption data, demographic data, social network data on discussion and patient referral ties among doctors, and individual-level sales call data provided by a pharmaceutical company. The authors found evidence of social contagion in new drug adoption (after controlling for doctor-level marketing efforts) and argued that targeting heavy users (a practice common in the industry) is a good pharmaceutical company strategy—doctors not only have a higher customer lifetime value, through exerting more social contagion, but also a higher network value.

The recent availability of administrative data from health insurance funds (Pham et al. 2009; Barnett et al. 2011; Landon et al. 2012) might also enable researchers to construct and combine social network data with the socio-demographic and professional characteristics of doctors. Such data allows researchers to construct patient-sharing networks where a link between two doctors represents caring for the same patient—due to referral, patient self-selection, administrative rule, or even chance (Barnett et al. 2011). In general, to coordinate patient care, doctors have to communicate regularly and effectively with the other doctors who share responsibility for the same patients (Pham et al. 2009), enabling them to influence the early adoption of new drugs.

The model for understanding the diffusion of pharmaceutical innovations is not pharmaceutical company–doctor–patient, but a model of the doctor as the node of a network involving pharmaceutical companies, other doctors, especially specialists, patients, and features of the drugs themselves. Prescribing is a form of social action, which involves understanding the network within which the individual doctor is embedded.

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RODERICK MARTIN

Introducing business historian Howell John Harris

> It is both pleasant and curiously unsettling to be told by my peers that nothing I've done since I was in my 20s has quite matched up to the stuff that I wrote before I knew how.
>
> Howell John Harris (2012)

Business historian Howell John Harris is Professor with the Department of History at Durham University in England. His first book, *The Right to Manage: Industrial Relations Policies of American Business in the 1940s*, was published in 1982. The book was based on his doctoral thesis, *Getting Everybody Back on the Same Team: An Interpretation of the Industrial Relations Policies of American Business in the 1940s*, defended in 1979. Highly unusual for a young scholar's first publication, the book was awarded the Philip-Taft Labor History Prize. Thirty years later, in 2012, the *Labor History* journal confirmed the book's enduring legacy with a symposium entitled 'Assessing Howell John Harris, *The Right to Manage*, after 30 Years'. However, Howell's rather unpromising doctoral beginnings would have never predicted his successful academic career, let alone the professional accolades that were to be bestowed on it ever since 1982. In 1974, for example, a tutor was concluding his comments on Howell's course paper as follows (Neufeld 1974):

> Apart from these lapses, which made your paper resemble a conventional term report, there is the obstacle of your prose style! Your ideas and your ability to develop them are first-rate. However, you conceal them under such turgid and undisciplined prose that I had to read every sentence several times in order to garner the full substance of your thought. Since your prose style is unfair to the reader, I picket you.

Howell's autobiographical essay published here recounts his experiences as a young business historian embarking upon a PhD (called DPhil, at the University of Oxford). Howell's account is very honest, showing the uncertainties, and the trials and tribulations, that even committed research students face—it is far from a triumphant pilgrim's progress.

The institutional circumstances in which Howell undertook his research at the University of Oxford and at Cornell University were very different from current conditions. Oxford, particularly in the social sciences in the 1970s, and Cornell were very different from each other, and both were very different from the current institutional context in Hungary. In the 1970s, there was no business school in

Oxford and no management faculty. There were, however, an emergent sociology faculty and a strong, research-oriented, industrial relations group. As for business historians, they were thrown on their own resources. In contrast, Cornell had a business school, a large sociology faculty, and an internationally distinguished New York State School of Industrial and Labor Relations, which is where Howell came to be based. Few institutions now have the financial resources available to Oxford and Cornell in the 1970s—less time, and less indulgence, is allowed to graduate students. Formal graduate programmes, with coursework requirements, structure research student time and provide guidelines, sometimes even instructions, on how to carry out research. Despite differences in time and in circumstances, Howell's autobiographical essay underlines at least three everlasting messages for all PhD students—as well as being entertaining in its own right.

First, there are many reasons for doing a PhD—curiosity about a subject in general or about a particular issue, for example, or the desire to follow a distinguished academic career or a career as a highly paid consultant. But one of the worst reasons for doing a PhD is doing a PhD because of the lack of an alternative—it inevitably leads to drift and lack of direction. Doing a PhD is a difficult, arduous, and often lonely journey, requiring high levels of personal drive and commitment—even in well-organised graduate schools, with careful and knowledgeable supervision. The second message relates to the importance of defining a topic—and, even more significantly, the importance of identifying a question which you are seriously interested in answering. Defining the research question, even more than finding a research topic, determines the scope of the PhD thesis—and the probability of successful completion. Third, relations with supervisors are critical. In some cases, PhD students are junior members of existing research groups. As such, the research question is defined by the PhD supervisor, the research methods are specified by the group, and the role of the PhD student is to apply these methods correctly. In other circumstances, students are left on their own. Universities, and faculties within universities, differ in approach. As Howell's account shows, in the 1970s, Oxford was at the extreme end of allowing students to define their own questions and methods of research—this *laissez faire* approach suited well very determined students, but was potentially disastrous for wavering students. Whatever the approach, however, relations with supervisors—as both mentors and first ports of call—are critical.

Management is a very diverse discipline, where business history is very different from, say, operations management—sources of data, ways of securing access, modes of analysis, and the structure of argumentation all differ. They differ to such an extent, in effect, that, despite their enduring relevance, management journals rarely venture as far as publishing business history articles. Therefore, it

is very much to the credit of both author and journal to publish such a candid, reflective account on becoming a business historian—a management article truly 'unusual in more ways than one'.

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HOWELL JOHN HARRIS

'The path I trod':[1] a portrait of the (business) historian as a young idiot[2]

The most obvious place to start is with my undergraduate 'Modern' (that is, post-Roman) History degree at Oxford in 1969–72. That was where I made my first proper acquaintance with American history, on an optional course in the summer term of 1971 called 'Industrial America and the Growth of Governmental Power', which was a state-and-society survey of the period from Reconstruction through the Progressive Era[3].

Why did I choose to specialise in modern American history, once I had completed most of my required courses?[4] I found modern British—or, as it was then more accurately described, 'English', which probably explains some of my problems with it—history tedious, apart from the Industrial Revolution, and my only foreign language was French, so modern European history did not seem like a good option either. My Latin was good, and I found medieval history fascinating—but, again, no German, so that was a non-starter too. And finally, I knew the course would be well taught by an inspiring tutor, John Walsh, and that was really enough to clinch the argument. 'Industrial America' was where I first read American statutes, court decisions, political rhetoric, and social theory and encountered the work of the 'greatest generation' of American historians (John Hope Franklin, Samuel Hays, John Higham, Richard Hofstadter, Comer Vann Woodward, Robert Wiebe, and others). Two of the essays I wrote on the course turned out to be particularly important for me. One was about the organisational problems of the American labour movement in the Gilded Age and Progressive

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1 With apologies to Terence Vincent Powderly (1849–1924), Grand Master Workman of the Noble and Holy Order of the Knights of Labor (1879–93), who used this title for his autobiography, published posthumously (Powderly 1940)—it seems not entirely inappropriate here. I first came across Terence Vincent Powderly on the Industrial America course in 1971, and then again on ILR 702 in 1974.

2 The first version of this article was published in 2012 at http://www.dur.ac.uk/h.j.harris/TRTM/TRTM-The_Path_I_Trod.doc.

3 Circa 1865–1916.

4 David H. Burton gave a good picture of the state of US history in British higher education when I first experienced it as a student at one of our most conservative institutions (Burton 1973).

Era[5] and seems to have had an influence on much of the rest of my professional life.[6] The other was on the consolidation of business power in the late Nineteenth and early Twentieth Centuries, and was my first meeting with the work of Alfred D. Chandler, Jr. But I didn't read much of it at the time, and remained ignorant of most of it for years afterwards. Some reviewers of my first book, *The Right to Manage: Industrial Relations Policies of American Business in the 1940s* (Harris 1982), would fit it into the then-dominant, post-*Visible Hand*, 'Chandlerite' framework for business history, but, in fact, he had little impact upon me, then and since. Most of my understanding of the 'strategy and structure' of the large corporation in the Twentieth Century US would come from other sources, notably the works of Richard Averitt (1968) on structure and Thomas Cochran (1972) on strategy. In terms of my approach to the history of business, probably the most important thing that I read forty years ago was a little book that I would still recommend to anybody, Edward Chase Kirkland's (1956) *Dream and Thought in the Business Community*. Kirkland instructed me never to approach the history of businessmen without paying serious attention to their beliefs and their fears, whether rational or otherwise. This was a lesson that I was happy to learn, because it fitted in with what I thought (business) history should always do anyway—enable the reader to understand the past from the viewpoint of the protagonists. That is not the only thing to ask of an analytical narrative, but it is surely essential.

Britain in the early 1970s was a good time and place to run across the history of 'the labor problem' in late Nineteenth Century America, because we certainly had our very own version of the same phenomenon. My memories of student life are full of power cuts caused by coal miners' and electrical workers' strikes, months without mail from home because of postal strikes (which then affected the nationalised telephone monopoly too, producing weeks of free calls after students discovered the phone engineers' access code, which went unchanged until after the strike was over), and other instances where unionised workers and labour relations impinged on everyday life in a way that seems almost unimaginable nowadays. I was not a very politically aware student, though I did read the papers. I attended one pointless sit-in about nothing very much at all, and went to the occasional

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5 Circa 1870–1916.

6 My memory tells me that the focus of my work was on employers' opposition to unionisation, but, unfortunately, the old essay itself informs me that I have rearranged the past too neatly, and that this was just the last of my four explanatory themes. I also 'remembered' that this was where I had first encountered my future mentor and friend David Brody's (1960) classic *Steelworkers in America: The Nonunion Era*, but it turns out that this is wrong too, and my reading at the time was more limited than I later imagined. Another proof, if any were needed, of the superiority of documentary evidence over unassisted and unverifiable recollection.

demonstration, but, even then, I thought student politics to be little more than a game. We knew that more important things were going on in other places, and we wanted some pale reflection of them in our little Oxford lives too.

The great thing about the strikes of the early 1970s was that, even if you were not very political, you couldn't ignore them. But what did they mean to me? Not a lot. It's conventional among career biographies of labour historians of my generation to speak about formative political experiences and commitments—'How I Discovered the Working Class', etc.—but I don't really think I had any, and I didn't really need to discover the working class because they (or at least a few of them, in a small ex-quarrying village in North Wales that was rapidly losing its Welsh Nonconformist culture of poverty in the 1950s and replacing it with nothing much at all, as it became increasingly well integrated in the 1960s into a modern, secular, and Anglophone culture of consumption) were the people among whom I had grown up.

Illustration 1 The author in very early training to be an American business historian (circa 1954).

My own family background was stuck somewhere between (1) the skilled and respectable working class (most of our friends and neighbours—building tradesmen, garage mechanics, and truck drivers, for example); (2) the lowest rung of the lower-middle class (my father progressed from being a farmworker, slaughterman, and butcher, by way of wartime service with the Royal Engineers that gave him experience in store and office work, and eventually got a poorly paid but salaried job as clerk and bookkeeper in a small firm of livestock auctioneers—when I got my first job in 1975, at the very bottom of the university lecturer pay scale, my starting salary of GBP 3,174 (GBP 20,800 to GBP 32,600 in 2010 values, depending on which conversion method one uses) at age 23 was already more than my father, then 56, had ever earned); and (3) the more secure lower-middle class status of other close

family members who owned their own homes and cars, had TVs and telephones, went on holidays, occasionally even 'Abroad', had sometimes received an education beyond high school, and held semi-professional jobs in education and other public services (librarianship, tax collection). Yet other, older family members and friends included small farmers, building contractors, and shopkeepers, who were really just self-employed rather than small businessmen in any real sense, and, from a previous generation, real entrepreneurs—my maternal grandfather and his brothers, for example, who had run a marine salvage business from the 1900s until the 1940s. I spent part of my childhood among the memories of that risky business, when I went to visit my grandparents for the school holidays, and the rest of it living in a small rented house behind the village butcher's shop of my great uncle John, our landlord. I never knew the world of the urban, industrial working class[7], and never really wanted to—and I never rejected most of the values of my family and community (apart from their religious beliefs and practices), including their aversion to alcohol (I took the Pledge in a Band of Hope meeting as a child, but started backsliding once I got to college—however, I remained a firm adherent of the religion of 'Anti-Tobacco'). Working hard, getting a decent job, not hoping for too much, not taking risks, not spending money I didn't have, saving for the future, caring about respectability before many other things, and aiming to get along with people, but not being too open with them—the village values have been good enough for me; or, at least, if they have not been, if in some respects they have limited my ambition and imagination, it is too late to change now.[8]

[7] Oxford in the late 1960s and early 1970s still had a significant manufacturing base, but the closest I came to its working class was getting a very good kicking from a bunch of Morris Motors apprentices out for their traditional evening's entertainment after their Thursday payday: going into the middle of town to get drunk and beat up students. This happened during my first week away from home, and was quite memorable. Apart from that, I had the usual contact with college servants, which always made me feel uncomfortable—my mother extended our inadequate family income by cleaning middle-class ladies' homes in winter and working in a small hotel in summer, so I had a hard time dealing with the deferential manner of the college 'scouts' and waiters paid not very much to look after me, thinking that I came from the servant classes myself, not those born to be served like so many of my peers. Some of the most characterful of the college servants made it much easier and more interesting to deal with them, because they were so insolently insincere, angry, slothful, and very sloppy—as if they had taken hints on appropriate deportment from some of the early works of Evelyn Waugh or Tom Sharpe.

[8] These values are close to those of the English urban-industrial working class of a previous generation—so memorably evoked in 'Part I' of Richard Hoggart's (1957) *The Uses of Literacy*—and not far from those of some of their American contemporaries described in John Bodnar's (1980) 'Immigration, Kinship, and the Rise of Working-Class Realism in Industrial America'. So, I almost took it as a compliment when my

If the personal is political, then my persona was clearly *petit bourgeois*, even if our household income didn't match up to that standard, and I followed a classic life course from village to town, grammar school to university, and eventually into the kind of secure and fairly undemanding, low-risk / low-reward, unexciting-yet-respectable career that suited my character. Why may this admission be semi-relevant here? Because it's clear that, temperamentally, I was never cut out to be a labour historian, particularly one coming of age in the early 1970s, when some of my middle- to upper-class Trotskyite acquaintances at Oxford still dreamed of revolution—a fantasy or nightmare that I never shared—and romanticised the lower classes—something I could not agree with either. Being poor and powerless never struck me as intrinsically admirable, and certainly not enviable—more a matter of bad luck, principally resulting from choosing the wrong parents. I had my own utopian tendencies, but I kept—and keep—them for private reveries, never confusing them with anything practical or attainable.

How did my essentially small-c conservative character (never, yet, resulting in voting Conservative—everybody has his limits) translate into an outlook that I expressed through my work, through the choice of subjects to study and ways to interpret them? Ideologically, I was almost always comfortable with a very centrist and merely reformist

Illustration 2: The author in very early training to become a historian of technology (circa 1954).

old friend and collaborator Nelson Lichtenstein (1987: 309) bracketed me with Bodnar and other scholars I respected—Mel Dubofsky, Dan Nelson, and Bob Zieger—as 'laborite realists'—though he might not quite have meant it as such. If history is not 'realist', true to the past, *wie es eigentlich gewesen*, what's the point? Interestingly, another old acquaintance, Christopher L. Tomlins (1993), included Lichtenstein himself as someone working alongside me in the pessimist-realist vein in his review of the essay collection we edited together, *Industrial Democracy in America: The Ambiguous Promise* (Lichtenstein and Harris 1993).

politics, moderately social democratic, at best. I believed, probably with more conviction in the 1970s than now, that some form of liberal capitalism was the only worthwhile game in town, and that the important question was therefore whether it would be well or badly managed, either by an interventionist state or by those in control of its most important organisations, the business firms. In early 1970s' Britain, it did not seem that either of our *élites* was especially competent, though neither was actively malevolent in the modern fashion. One of the attractions of the study of US business history came to be a sense that I was reading about people who knew what they wanted and knew how to get it—levels of practical ability and self-confidence in short supply in Britain at the time.[9]

The study of the history of business and increasingly of technology has also been a way of satisfying my fascination for stuff, for discovering how people produced the material ingredients of everyday life that my chosen profession does nothing else to meet (see Illustrations 1 and 2, pp. 93 and respectively 95). Of course, historical study only does so at second hand and almost entirely through reading—but this has always been a very adequate substitute for real experience for an introverted swot like me, who spends most of his time living inside his own thoughts. And it's actually not a bad substitute—for example, it was years after I had started reading about metal-casting technology before I actually saw the inside of a foundry (a small jobbing enterprise in Royersford, Pennsylvania, introduced to me by an old friend, Bill Adam, who was a lifelong Communist as well as a skilled patternmaker and small businessman), but I found that I knew exactly what I was looking at and how it worked. Words didn't fully describe the dust, smell, and heat, but they were pretty good for everything else.

After that biographical excursus, back to the labour problem in Britain in the early 1970s. Among the unsuccessful remedies attempted was our own version of Taft-Hartley[10], in the shape of the Conservative Heath government's Industrial Relations Act of 1971, so questions to do with workers' power, management's resulting problems, and the state's response were certainly on my agenda. I followed 'Industrial America' with a final-year course—a fifth of my entire degree—on 'Franklin D. Roosevelt and the New Deal'. Choosing it was easy—the

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9 I formed this perception of the American business community at a very particular time, near the end of a period during which, according to Mark S. Mizruchi (2007), a perceptive analyst, it had indeed behaved as an intelligent ruling class.

10 The Taft-Hartley Act was the major achievement of the 80th Congress (1947–9), the first that the Republican Party had controlled since 1930. It amended the Wagner (National Labor Relations) Act of 1935, the foundation on which the American labour movement had grown in power through the intervening years, and assisted employers in recovering the upper hand.

line of least resistance, or of natural progression, after 'Industrial America', with the added attraction that it would be taught by William Leuchtenburg, who was visiting Oxford at the time. More statutes, more judicial opinions, more social and economic thought, and, of course, a lot more labour history. I lapped it all up, and also recall reading Howard Fast's (1962) novel *Power*, a lightly fictionalised account of the career of John L. Lewis[11] which gave me a sense of the trajectory of the new American labour movement of the 1930s and 1940s, from excitement to disappointment and finally containment. Or maybe I am tidying things up here too, and the novel came first, borrowed from Colwyn Bay Public Library when I was still at school, with the interest in American labour history latent thereafter, and just waiting for some intellectual stimulus to spark it into life, which my coursework provided and everyday life under the Heath government encouraged.

The other course I did at university that helped directly with the development of knowledge and skills that would be useful to me in the years that followed (though they all did, in a sense, because they got me used to reading quickly and carefully) was the capstone of my degree programme, an 'Introduction to Political Thought' with another fine tutor, Richard Grassby—then a specialist in early-modern business history (Grassby 1999), now also a realtor in Maryland. 'Pol. Thought' was a compulsory part of a Modern History BA, and many people hated it, but I didn't. The classical authors whose texts I read—Aristotle, Machiavelli, Hobbes, Locke, Rousseau, and, I think, Montesquieu—were not, perhaps, the ones most obviously relevant to somebody who was going to make a career from the study of US industrial relations. But 'Pol. Thought' did teach me to take political ideas seriously and to read texts closely, and, when I finally got around to absorbing American businessmen's ideological statements and exercises in political analysis, as a graduate student and afterwards, I always treated them as if they deserved as much attention as the work of my past masters. If this seems a bit highfalutin, maybe I should rephrase it and simply say that 'Pol. Thought' did for me one of the things that it was supposed to: it taught me to read political rhetoric.

When my first degree was drawing to an end, the obvious question arose: what next? I never really knew what I wanted to do for a living—the only job that I applied for was as a journalism trainee on the *Western Mail*, which was then a part of the Thomson Organization. But even after I had won it I had no idea what the job would amount to, apart from writing, which I thought I was good at. (Wrongly, as a cursory reading of any of my juvenilia will demonstrate—and in any case, the (bad) academic writing of which I thought that I was capable would have offered

[11] John L. Lewis was the leader of the United Mine Workers of America who set up the Committee for (later Congress of) Industrial Organizations in 1935, to take advantage of the Wagner Act and the uniquely favourable environment for union building that it created.

no guarantee that I could have made a success of an entirely different style of work.) So, I was easily persuaded to stay and pursue a doctorate instead, which would involve doing a lot more of something I thought that I enjoyed and was good at, in a place that I loved—the architecture of Oxford is very seductive. In comparison, the idea of becoming, perhaps, 'Our Man in Merthyr Tydfil', reporting on local folk customs (such as rugby games and mining disasters), having to drink far more than I was comfortable with and, probably, to take up smoking too (occupational requirements of the mid-1970s journalist), while waiting for the call from *The Times* that might never come, was insufficiently real or attractive. Once again, I followed the line of least resistance, sticking with the familiar through not having any strong inclinations to do anything else. I had no idea what graduate study would be like, but I threw together a 'research proposal' out of a few ideas left over from a 'New Deal' essay, then won a scholarship on the strength of rewritten versions of a couple of 'Industrial America' and 'New Deal' essays, good references, and an ability to interview well.

Americans who have gone through even the least distinguished graduate programme can have no idea of how unstructured, individualistic, and amateur the 'training' of a graduate student in History was almost forty years ago, in what liked—and still likes—to think of itself, with a fair measure of justice, as one of the finest universities in the world. The assumption seems to have been that, as I could write good, short essays when a tutor gave me the title and a reading list, and had managed to scribble lots of even shorter essays in response to tricky and unpredictable questions in thirty hours of final examinations crammed into five days (my coursework through three years counted for nothing in determining my degree class), I was obviously a smart chap and therefore ready to be let loose on a PhD—or, as we termed it, DPhil—without further ado. I could sound plausible enough about my misbegotten 'research proposal' in an interview, but I had no theoretical or methodological grounding in the arts and crafts of historiography, had never had to construct a bibliography of my own, had never seen the inside of an archive, never written a footnote, couldn't type, and had not the haziest notion of what I was really supposed to be doing as a graduate student, or why.

My first 'research proposal'—an extremely unimaginative plan to explore the connections, whether of influence or interest or mere coincidence, I wasn't sure, between 'Britain', whatever that was, and 'the New Deal', whatever that meant—collapsed very quickly when I attempted to pursue its worthless ideas into the university's libraries.[12] That only took a few weeks, and afterwards there was no

[12] The ideas weren't completely worthless, and versions of transatlantic comparative history, something that comes naturally to a business historian of the US working in Britain, have continued to interest me—see especially Harris (2007), the very belated product of a research project I began after *The Right to Manage* had been published in

structure of required readings or lectures or seminars or training courses to keep me busy, leave alone provide me with some direction. There were, however, my fellow students at Nuffield College—a small, very competitive, and privileged enclave of eminent social scientists and about fifty graduate students who were, by the standards of the early 1970s, an impressively cosmopolitan bunch, more mixed in age, nationality, gender, sexuality, and, to an extent, race than any I have known since, and probably smarter too. If I learned anything in my two postgraduate years at Oxford, I learned most of it from them. With their guidance, I read some political science, a bit of sociology, and some economics. I came across Harry Braverman, when he was new[13], and Antonio Gramsci, when he was long dead but experiencing a comeback[14], though I never made it as far as Karl Marx, whom most of my friends still took very seriously. I chatted with colleagues about their industrial relations projects, and envied them the prospect of doing fieldwork, getting data, and knowing what to do with it.[15] As for me, I was completely lost, failing to establish a working relationship with quite friendly and available but not particularly suitable supervisors (it would have helped if I could have pretended to be interested in cricket, the preferred conversational topic of one of the distinguished scholars through whose rooms I passed), drifting and drinking for months. Oxford University's pedagogical theory was basically 'sink or swim', and I sank.

1982, and put to one side after I had become interested in the Philadelphia Metal Manufacturers' Association, only to pick it up again almost 20 years later, having continued to gather material all the while.

[13] Braverman (1974) impressed lots of people, including my supervisor, when it was first published, though its account of the history of industrial labour has not stood up to careful scrutiny.

[14] I cannot recall which particular bits of Gramsci I read at the time, probably just parts of the recently translated *Prison Notebooks* (Gramsci 1971), but what I took from them was absolutely conventional—the language, if not a very sophisticated understanding, of his hegemony theory.

[15] I don't recall learning anything, or even having much to do, with any of Nuffield's distinguished fellowship apart from my college tutor, who always regretted that I wasn't doing proper political-science history, but still tried to take an interest and help out. One of the fellows, the economic historian Max Hartwell, whom I should probably have made more of an effort to talk to, described the college to a bunch of us disgruntled graduate students as a first-class waiting room. It was comfortable, the food and company were good, and it didn't really matter too much what we did or didn't do while we were there—we were more or less guaranteed goodish careers merely on the strength of having attended. Hartwell turns out to have been more or less right. Few of us ended up unemployed, and some of my contemporaries have already picked up knighthoods or even bigger gongs.

However, I did not want to be thrown out, particularly because I was embarking on my first proper adult relationship, which I am sure was my most important reason for wanting to stick around Oxford a while longer. So, I had to do something to justify my presence, or at least to maintain a convincing pretence that I was employing my time usefully, even though I wasn't. I liked the life, the comfort and good food, the company, and my scholarship income from the government and my college, and I still had no idea what other career I might wish to pursue if I dropped out. Nuffield was an ideal place to do nothing much—it was easy to while away the days, and the relatively brief intervals between breakfast, lunch, and dinner in hall were usefully punctuated by coffeetime and teatime in the Common Room. In summer, croquet or punting could fill up some of the remaining free hours; in winter, I even tried squash, which, given my poor eyesight without glasses, and bad coordination, was quite punishing, and indicative of how desperate I must have been for something to do; and in the evening, at all seasons, there was always talking and drinking, and, for much of 1973–4, the nightly entertainment of the 'Watergate' show on TV.

But, in order to hang on, I needed to give the college some better evidence of what else I had been up to, in order to persuade them to renew my scholarship. So, as a survival strategy, in the spring of 1973, I cobbled together a quite interesting paper on 'The American Keynesians', mostly from scraps of knowledge left over from my 'Special Subject' the previous year. My motivation to do this was purely instrumental, but I discovered that I actually still liked reading new and complicated stuff (notably about the theories of 'secular stagnation' and 'mature economy' and their policy implications) and seemed to be quite good at making sense of it. So, having persuaded Nuffield's fellows not to terminate me (I am sure, in fact, that there was little risk, but it was good that I was afraid), with the aid of something that was a bit of a con trick, I decided that I might as well make another, more serious attempt to find a research topic that had legs.

The way I did this was quite simple. I asked people I knew a bit, and respected, if they could suggest any leads to follow. Maldwyn Jones, professor of American History in London, who had been my older brother's tutor at Manchester when he did an MA in American Studies there in 1971–2, said the domestic history of World War II was an open and interesting field, and, as I had read about the New Deal, I would understand it well enough—he sent me off to read Jim F. Heath (1971), which set me on the right path. William Leuchtenburg agreed. Lloyd Ulman, also passing through Oxford as a visiting fellow, told me that the history of wartime labour relations hadn't really been done. So, I might as well do it.

The college library was full of stuff for me to read, and, as it was open stack and rationally organised according to the Library of Congress classification system, it didn't matter that I still had no idea how to construct a bibliography—I could simply wander along the shelves in more or less the right place and pull out

anything that looked interesting. My college tutor, Philip Williams, an enthusiast for the study of the American political system, also helped me dig myself out of my hole by enabling me to switch from the Faculty of Modern History, where I could still find no useful supervision, to Sociology. There, I hitched up with Roderick Martin, a historian by training who was reinventing himself as a political and industrial sociologist, *en route* to a final destination as a professor of management. Rod did not know much about US labour relations either, but he was prepared to read and comment, gently but critically, on whatever rubbish I wrote, which was probably more useful to me than anything else could have been at the time. He also, I think (or it could have been Peter Fairbrother, a Nuffield friend doing an industrial sociology doctorate under Rod's supervision, or Mike Terry, an institutional industrial relations specialist), introduced me to the work of the intellectual star of the 'Oxford School' of industrial relations, Alan Fox, whose masterpiece *Beyond Contract: Work, Power and Trust Relations* had just been published (Fox 1974). Fox provided me with my essential understanding of managerial ideologies, and I found that many of his categories suited US historical realities very well—my later definition of 'unitary corporatism' (Harris 1993) was almost pure Fox.

Of all the things I read at Nuffield in 1973–4, probably the most useful were the topically organised clippings files of wartime US newspaper coverage of labour relations issues—that had been compiled at the time by British political-intelligence operatives, and that had ended up, by some happy accident, in my college library—and the long runs of two American magazines, *Fortune* and *US News and World Report*, both of which provided extensive coverage of the labour beat. After reading my way through them all, I knew my way around the people and the organisations involved in the political economy of wartime and post-war labour. *Fortune*, in particular, also got me hooked on business history—I was seduced by the quality of the rich, heavy paper, the wonderful typography and artwork, and the cleverness of the reporting—and concluded that *Fortune*'s intended readership was evidently a group of people worth studying.

My doctoral study through the rest of 1973 and into early 1974 continued to be a messy and inefficient process, but, by the end of it, I did have the outline of a research topic that I could, perhaps, believe in. I had acquired a good level of knowledge and understanding about labour relations in the wartime US, and I was following the 'responsible' union movement down the road toward Taft-Hartley, along the path pointed out to me by Howard Fast and also by a new discovery I made as a guide to the recent American past, again thanks to my fellow students—C. Wright Mills, whose *The New Men of Power* (Mills 1948) became my bible.

And then I ran into a problem: I was exhausting the printed sources in the Oxford libraries, or at least I thought that I was—if I had known how to use them properly, I would not have been so worried, and I could always have taken a 50-

mile train ride to London and used the British Museum and LSE[16] libraries to extend my range. In any case, I knew that, just as my industrial sociologist friends had to do their fieldwork in strange old places called 'factories' (which were still quite common in Britain forty years ago, though younger readers will probably not have the foggiest idea what they were like, unless they have seen pictures of them in TV documentaries), at some point I had to use what were to me equally unknown places called 'archives', and they were all in the US.

So, I had to leave Oxford—a decision made easier by the collapse of what seemed at the time to have been a long affair, at least a year (a year is a long time when you're 21 or 22), whose beginning the previous spring had been the major reason why I didn't want to depart from Oxford in the first place. Now, after almost five years in town, I was finally ready for a change of scene. I applied for a Fulbright Scholarship and got it, but, in those days, it only covered travel and medical insurance, so I liquidated all the savings I had accumulated as a student, about GBP 1,500 (USD 3,500), which would be worth at least GBP 12,000 (USD 15,500) nowadays (or, by a different conversion method, allowing for the growth in average real earnings in nearly forty years, almost twice as much). Those were times of no tuition fees and generous grants for living expenses, and I had also done some well-paid teaching while I was a graduate. I borrowed the rest of what I needed from a couple of very supportive maiden aunts and also from my college, whose only condition was that I should take out a life insurance policy naming them as the beneficiary, to make sure that they would get paid back even if America proved fatal for me—I think they also threw in a grant of several hundred pounds.

Philip Williams, who was instrumental in getting the college to back me, and Rod Martin had both spent time at Cornell, so they thought it would suit an untravelled provincial hick like me who could not imagine living somewhere too far from a hill, lake, river, or woodland and was much too young and naïve to be let loose in a big city. It had a fine research library and an excellent history department—I would work with one of William Leuchtenburg's old students, Richard Polenberg—and would be a good base from which I could make forays to the mysterious 'archives', when I could figure out which ones I needed to visit, and why.

These plans changed before I ever reached Ithaca, because, on the Greyhound bus from Syracuse, I overheard the English accent of an attractive blonde woman in the seat in front of me, and we got talking.[17] It turned out that she had been to

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[16] London School of Economics.

[17] Her nickname, I later found out, was 'Crash'—an ironic but literally true comment on her skills as a light-aircraft pilot. I only flew with her once, on what was supposed to be a short trip to Rochester Airport to pick up a friend arriving by scheduled service. She

university just 20 miles from my home in North Wales, and had even married a man from my old grammar school, before immigrating to Canada. She was now a qualified accountant, single again, and pursuing a doctorate in Organizational Behavior at the New York State School of Industrial and Labor Relations (Cornell University ILR School nowadays or, simply, ILR). She explained to me that, as the ILR was a state school, the fees were peanuts, even for a foreigner, in comparison to the Ivy League rates charged in History, and you still had access to the same facilities. As I was paying most of my own costs it seemed to me that the argument for ditching History in favour of ILR was unanswerable, a no-brainer, and I did it as quickly as I could after getting off the bus and finding my room in Cascadilla Hall, next to one of Ithaca's famous and beautiful gorges, favourite sites for the many student suicides ('gorging out', in the local vernacular) that seemed to litter the semester. I did get to meet Richard Polenberg at least once, but, though I was able to pay off most of my debt to Nuffield immediately, had a lot more free cash as an ILR student than I otherwise would have, and ended up with much less to repay once I started earning, I found myself back to square one in terms of latching onto a supervisor.

Of all the labour historians on the ILR faculty at the time, I fetched up with Maurice F. Neufeld as my mentor, for no reason that I can recall. Perhaps his faculty colleagues thought that, as his name almost rhymed with Nuffield, he would help me to feel at home; or maybe they just felt that he needed more work. He was probably the least appropriate for the research that I was doing, apart from the fact that his memory of the 1940s was very good. We established some sort of working relationship, but it was not close—symptomatically, I spelled his name wrongly in my book's 'Acknowledgements' (Harris 1982: viii). He was generous with lunches and drinks in the faculty club next door to the ILR, run by students from the excellent hotel school, and helped me with a couple of useful contacts, but was not otherwise very engaged. (And why should he have been? I didn't have much to offer.) I started one course with him, a very conventional-wisdom canter through American labour history that would not have been out of place in Selig

was trying to keep up her flying hours, and was a bit rusty. After a first attempt at landing on the wrong runway, we made it down safely, but, on the way back, her friend, completely unqualified and an utter berk, insisted on having a go. We ended up lost over Upstate New York, as winter's darkness fell, and the needle on the fuel gauge fell with it, unable to tell one Finger Lake from another, but unwilling to radio air traffic control as she didn't want two incidents on her log book in one day. Eventually, we worked out which lake was Cayuga, and found Tompkins County airport again, landing safely on the icy tarmac, but with quite a bump. Though I did not know it at the time, our route took us right over Palmyra, NY, the birthplace not simply of Mormonism in the 1820s, but also—and of much greater interest to me—the large-oven, wood-fired cooking stove a decade later.

Perlman's Wisconsin decades earlier[18], which was probably where it came from, but fairly rapidly concluded that it was not a very good use of a third-year DPhil student's time—and 'the Neuf' certainly did not think that I had risen to the challenge of the opportunities he provided either.

I had very little to do with the other labour historians, any of whom would probably have been much more stimulating—Cletus Daniel, Roger Keeran, Gerd Korman, or James A. Gross, the first volume of whose great work on the National Labor Relations Board had just been published (Gross 1974), or the labour law and collective bargaining scholars—notably George W. Brooks and Alice Cook, or the sociologists and organisational behaviourists—particularly William F. Whyte. I was in the same building as all of these excellent people, but they might just as well have been on Mars for all the contact I had with them; which was of course my fault, not theirs. Instead, I did pretty much the same as I had at Oxford—I read tonnes, only with an almost infinitely better library to play around in, thought about it a lot, but didn't spend enough time talking to anybody about it, which has always been one of my weaknesses.

My most important regular contact was with Rich Strassberg, archivist in the Labor and Management Documentation Center on the ground floor of the ILR Library, where I spent much of my time, ploughing through the 'Vertical Files'[19] and 'Company Files' full of 'grey literature'[20] from the 1940s produced by labour unions, business corporations, and pressure groups with an interest in the labour problem. The rest of the time I was upstairs, scouring the shelves for hardback publications on labour management and employment relations, and going through serial publications (business and management magazines) that were relevant. The highpoint of the day was coffeetime, when I wandered across to meet the other graduate students and ate enough cheap doughnuts to keep me going until dinner. Occasionally I had to visit the great Olin Library at the centre of the campus, but generally the ILR had what I wanted. My focus was on what businessmen thought and feared, as evidenced by what they said, wrote, and did. My book's bibliography is full of some of the results of all this effort (Harris 1982: 205–79)—

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[18] Research that has not been published or that has been published in a non-commercial form.

[19] Collections of resource materials—such as pamphlets and newspaper clippings, for example—stored upright for ready reference.

[20] Maurice F. Neufeld did his bachelor's, master's, and doctoral degrees at the University of Wisconsin in Madison in the early 1930s, where John R. Commons and Selig Perlman were still developing the 'Wisconsin School' of labour history that remained dominant into the 1960s. By the 1970s, it had been displaced by the 'New Labor History' of David Brody, Melvyn Dubofsky, Herbert Gutman, David Montgomery, and others, but Neufeld's teaching made no noticeable concessions to modern ideas.

hundreds of happy hours spent doing what I do best—the rest sits in my card index of references and several boxes packed with notes, which are only not yellowing because they were typed on yellow-pad paper to begin with, so it's impossible to tell.

Midway through my first semester, I finally took off for 'the archives'. By this time, much of my research focused on the automobile industry—so, a trip to Detroit was unavoidable. It was affordable, because I had persuaded the British Department of Education and Science that it was essential for my work, and it was also an attractive prospect because it meant temporary deliverance from Cascadilla Hall. I had never had to share a bedroom, since my older brother left for college, and, through five years at Oxford, one of the enduring pleasures had been a room of my own (the last one, at Nuffield, quite palatial)—it gave me a lifetime taste for large, light, fairly empty spaces to live and work in. But, in Ithaca, I found myself thrown into my own private Animal House with an American student supposedly pursuing a professional master's degree, but doing so in a very self-destructive way. He was morbidly obese in a way which was then still quite rare, especially among members of the educated white middle class, and of pretty revolting personal habits—a sad character who seemed to spend most of his life in bed, watching TV, smoking, and guzzling huge bottles of bourbon and cardboard tubes of Pringle's chips that he picked up on weekend trips home to watch the Buffalo Bills. The resulting disgusting sounds and smells punctuated our short life together. Sometimes he got out of bed long enough to cook horrible, greasy hamburgers in an electric frying pan, stinking out the room (whose windows did not open, and which was already intolerably hot because the ancient central heating seemed to have been turned up to boiling point as soon as the season began to turn deliciously cool outside). It was an awful living and working environment, and the sound of his nocturnal fantasies as he humped his bedclothes—unrequited sexual longing blending with dreams of making touchdowns for the Bills into a very noisy mashup—was the last straw.[21]

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[21] I have found a 'Hello Mother, Hello Father' letter that I wrote home at the time, describing conditions in our shared 'pigsty' and only leaving out a few of the juicier details—'He's just beyond redemption. Dirty socks and keks [underpants] strewn around the floor . . . constant smoking, and ashtrays never emptied . . . cooking fatty food in the room, and leaving dirty, smelly plates, chicken bones, etc., around . . . an aversion to draught and fresh air, which means I lead a guerrilla campaign to drive away some of the sour odours . . . the TV till 12-30 or 1 a.m. . . . the guzzling of beer and crunching of crisps . . . the snoring, snorting, grunting, and sleep-talking which follow. Altogether, it's too much. He's not a bad guy, he's just an absolute slob.' He has gone on to a successful career in the hospitality trade, and according to Trip Advisor his hotel is not the worst in his city.

Looking back, it's clear that he must have been deeply troubled at the time, but, immature and self-absorbed prig that I was, I had no sympathy for him as I chewed my muesli, fruit, and yoghurt or ate my wholemeal bread, cheese, and spinach salads in the windowless rear half of the room, where I lived. The Bills didn't play enough games to suit me—each one brought a few days' respite and solitary possession of our shared space—so, I had to go somewhere, and the prospect of spending a few weeks in Detroit in early winter seemed positively delightful in comparison to staying in my graduate dorm a moment longer. So, my roommate was, I suppose, an inadvertent benefactor, a facilitator of my development as a researcher—the lack of anywhere comfortable to live meant that I spent all the hours I could away from Cascadilla, working very hard and socialising a lot, but by mid-semester I had had enough and wanted out.

Detroit was a revelation for me—the first large city in which I had ever spent any considerable amount of time. I found cheap accommodation (USD 14 a week) with a couple of guys in a rundown duplex a few minutes' walk away from the Wayne State campus, just across the Edsel Ford Freeway, and south of the old Burroughs Adding Machine factory. Once upon a time, it had been a nice middle-class home, with beautiful woodwork and maple floors, and an old hot-air furnace down in the basement to keep us warm with its heavy breath, but, by the mid-1970s, it was a very low-rent place, with holes in the ceiling—miraculously, the 4th Street residential enclave still survives, neither wrecked, cleared, nor redeveloped. My new roomies were doing master's degrees in archive management and working at the Reuther Library part-time to pay their way. I found them by writing to the Library before I left Ithaca and asking for my letter to be fixed to a student noticeboard, requesting a place on somebody's couch—they went one better, and gave me a bed in a room of my own. Their friendliness and normality made me forget Cascadilla Hall and my old roommate, and we had a great time. We shared the cooking and the shopping, and I was very impressed by the security at the checkouts in our local store—a big fat guard with a loaded shotgun across his knees, sitting behind a bullet-proof plexiglass screen on a balcony above. They also introduced me to local bars, particularly the Circa, and student parties. Detroit seemed to be a real party town. One of those parties, just south of campus, I remember particularly well, because a heavily armed local police SWAT[22] team stormed the house looking for a drug dealer on the run—they were actually surprisingly polite, came in through the front door, went out the back, made no trouble or mess, broke no heads, and did not seem to notice or mind the distinctive 1970s smell of the student fug while they were passing through.

In other words, Detroit was rough and dangerous to an extent with which I was completely unfamiliar, but (or perhaps 'so') I loved it. The city was going through

[22] Special Weapons and Tactics.

hard times in the winter of 1974, shortly after the first great oil crisis—I think this was when the great Chrysler plant on the East Side ('Dodge Main') closed its doors, or maybe I'm a few years too early and it was just a period of exceptionally heavy layoffs. Unemployment and poverty were everywhere, and crime too. The local TV news seemed to start with a fresh list of murders every night, some of them very gruesome—bodies only discovered down drains when the sewers backed up, etc. (I returned in the summer of 1975, just in time for one of the most celebrated Detroit murders in quite a while, the disappearance of Jimmy Hoffa[23], whose enormous banana-bunch hand I had shaken, very tentatively, and whose perma-tan complexion I had marvelled at—orange skin in mid-winter was rare in the 1970s, especially on middle-aged ex-convicts, not that I had ever encountered any before—when I met him after a lecture he gave at Cornell earlier that year.) The city still bore the scars of the 1967 race riots. I borrowed a bicycle to get around, and, when I rode across to Windsor in Canada or out to Dearborn to visit the Ford River Rouge plant and work at the company archives, I went through neighbourhoods that had been burned out, trashed, vacated, and never even cleaned up properly—the broken glass in otherwise empty streets was a real hazard, but I never picked up a puncture, still less a bullet. I am usually cautious and even quite fearful in American cities that are new to me, particularly after my cousin was gunned down by a couple of adolescent bag-snatchers in front of his partner and their son while they were visiting Baltimore on holiday from Somerset in 1981, but, in Detroit seven years earlier, it wasn't that I was fearless—it's that I was completely without imagination, and nothing was going to happen to stop me enjoying myself.

I found Detroit aesthetically exciting, too. I had entered the US from Canada, and took the Greyhound to Ithaca from the top end of Lake Champlain, around the north-west edge of the Adirondacks. So, I had never seen industrial America before my bus ride across the bleak Ohio Turnpike and through Cleveland and Toledo, where there were still plenty of belching smokestacks.[24] After that fine

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[23] Jimmy Hoffa was leader of the International Brotherhood of Teamsters, one of the strongest and most corrupt US unions, with close links to organised crime. He had been imprisoned in 1967, and released by Richard Nixon after just four years of a 13-year sentence. When I met him, early in 1975, he was attempting to rehabilitate his reputation and regain power in the union—the probable cause of his murder in Detroit that July.

[24] I always was an architecture buff, and it's clear that I was a naturally born sucker for what John R. Stilgoe (1982) termed the 'industrial zone aesthetic'. As Detroit was my first proper experience of urban-industrial America, it imprinted itself upon me, and, afterwards, I added to it with knowledge of other such zones—the trackside wreckage along the railroad corridor from New York to Philadelphia, the devastated area of Philadelphia between Germantown and Center City, etc., or, from much briefer

introduction, I was ready for Detroit, which struck me as magnificent—the Art Deco buildings, the Art Institute with its Diego Rivera murals, the huge modernist auto and other factories by the great Albert Kahn and his imitators, the immense and brutal concrete freeways, not to mention the wonderful pollution-dyed sunsets seen across miles of dereliction and squalor, the decaying low-rise housing not blocking the huge sky view. And, in among the spreading ruins, there was still plenty of wealth—the Indian Village enclave, where I met an old GM executive who had worked with the company's chief labour relations strategist and ideologue in the 1930s and 1940s, or Grosse Pointe, or early (failing) attempts at inner-city regeneration through building fancy modern apartment complexes to attract creative types back to the downtown, where I found myself drinking with some very odd people. I saw other parts of Detroit too, the suburbs to which the white working and lower-middle classes had flown, and which, when I returned in the early 1980s, were already being deserted in their turn.

And, by day, there was plenty of work—in the Reuther Library, in the Burton Historical Collection at the wonderful Public Library (since, sadly decayed), out at Ford's in Dearborn, and even on one of the upper floors of the old GM Building, where the friendly Industrial Relations staff gave me some contemporary printed stuff to read, after telling me, with a smile, that there was a goldmine of material for me in their archives next door, and they were never going to let me or anybody else see any of it, not even a single page.

Altogether, my few weeks in Detroit stand out in my memory as an almost perfectly happy time, and also the most creative period in all of the years that I was working on what became *The Right to Manage*. When I left Oxford, in August of 1974, I still didn't really know what I was doing or where I was going with it. September and early October in Cornell had begun to set me on the right track, with plenty of reading and some useful conversations with my fellow students—it is always helpful to have to try to find an answer to the friendly questions 'What are you doing here? What is your work about?' Late October and November in Detroit really helped me make my mind up. When I returned to Ithaca, just in time for Thanksgiving, I finally knew what I wanted to do. Everything seemed to fit into place, including the things that (I later discovered) I did not understand at the time, and most of what I didn't know by December 1974 would turn out to fit in too. After that, it was all plain sailing—a lot more to read, but I knew what sort of thing I needed to read, and why; a lot more thinking; and, of course, all of the writing and rewriting. But, in essence, by early December of 1974, shortly after my 23rd birthday, I had the germ of a book in my head, and all I needed to do was let it grow, feed and water it, prune it, shape it, and in due course harvest the fruits.

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acquaintance, central Pittsburgh and South Chicago—so that I developed a sense of the physical environment in which the history I read about had taken place.

There were, of course, plenty of hurdles to overcome, a couple of them immediate. The first was to sort out my relationship with the Cornell University authorities. In my absence, they had discovered my roommate's gross violations of the safety code, which was supposed to be very strictly enforced in Cascadilla Hall, an old firetrap before its reconstruction in the early 1980s. Refrigerators, toasters, and electric frying pans in rooms were absolutely illegal, especially if powered from long and dangerous extension leads snaking out into the corridor or plugged into sockets they weren't designed for. When I got back to Ithaca, I found that my roommate had disappeared, but that, in the eyes of Cornell, I was jointly responsible for his sins, and, as he had fled, I was supposed to carry the whole can by myself. So they wanted to get rid of me too, which would not have impressed the Immigration and Naturalization Service or the Fulbright Scholarship people at all, and would have put a nasty crimp in my plans for a doctorate. Fortunately, I managed to write and talk my way out of difficulty, making Cornell's Judicial Administrator laugh at my account of the few weeks I had spent in my roommate's company, and take pity on me for my university-imposed ordeal. Instead of getting expelled, I did not even have to pay a fine, and I was moved to a small room of my own, with a beautiful view down across Ithaca to Cayuga Lake and the hills beyond.

The second hurdle was that, having absented myself from many of the classes in ILR 702, I still didn't want a failing grade on the course, in case I decided to change my degree registration from Oxford to Cornell—a plan I had been considering for weeks, though with decreasing enthusiasm, as I came to understand that an American PhD would probably take longer than the jail time (allowing for good-behaviour remission) in a 'life sentence' for an ordinary murder at home. So, I had to throw something together to—I will not say satisfy Maurice, but—at least persuade that wise old bird not to plough me. The result was a long and incoherent paper, quickly bashed out, and not deserving anything better than the very generous B- it obtained. But it had at least one redeeming feature—the title, *The Right to Manage*, which I had probably cribbed from Eric L. Wigham's (1973) work on the (British) Engineering Employers' Federation, *The Power to Manage*. I remembered it five years later when John Jolliffe—Bodley's Librarian, a fellow of my old college, and its Dean of Degrees—told me at a Nuffield party when I finally collected my doctorate that the title I had chosen for my thesis (*Getting Everybody Back on the Same Team: An Interpretation of the Industrial Relations Policies of American Business in the 1940s*) would never do for a book. A book needed something short and snappy to go on the spine, four words at most, but three words would be better. Economy with words was never my strong point, but I had a four-word title available for recycling, and two of them were very small—so, *The Right to Manage* it was. And the rest is (business) history . . . .

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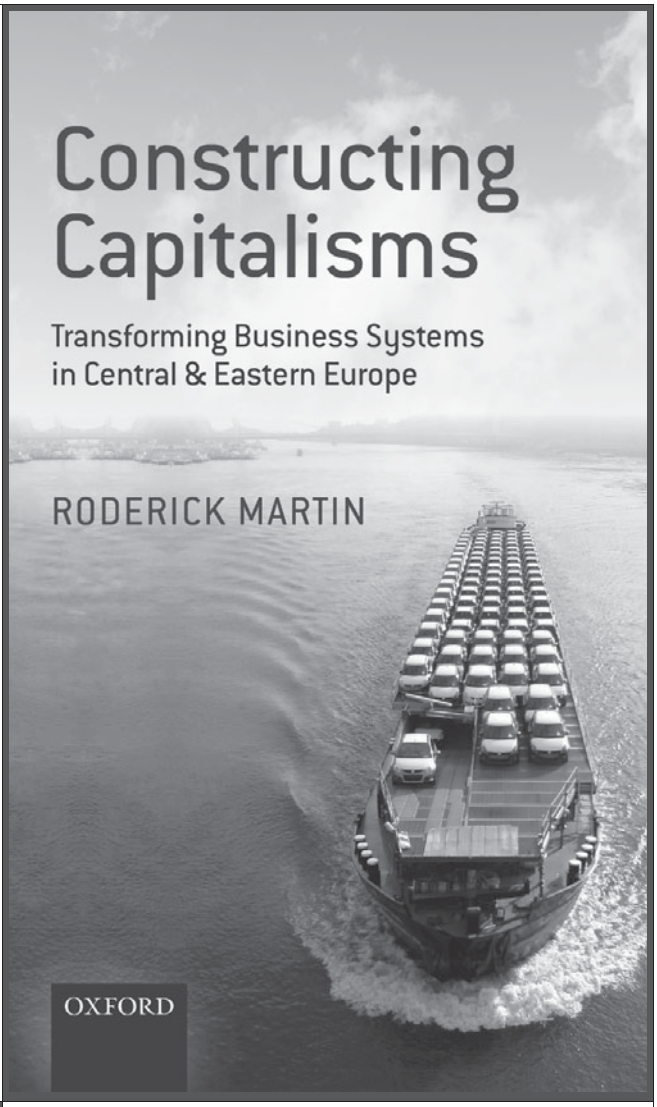

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