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BELIEFS, CULTURE AND CIRCUMSTANCE: A CRITICAL EXAMINATION OF THE CONCEPT OF PROFESSIONAL IDEOLOGY IN RELATION TO THE HEALTH AND SOCIAL SERVICES

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SUMMARY

BELIEFS, CULTURE AND CIRCUMSTANCE: A CRITICAL EXAMINATION OF THE CONCEPT OF PROFESSIONAL IDEOLOGY IN RELATION TO THE HEALTH AND SOCIAL SERVICES

The research described in this thesis is concerned with examining the views of a range of health and social service professionals towards policies devised by central government in the mid-1970s, relating to the care of particular patient or client groups, namely, elderly, mentally ill, and mentally and physically handicapped people. The policies called for priority in resource allocation to be given to these groups - although this was likely to involve withdrawing resources away from other groups (notably from the acute sector within the health service); they also called for a move away from institutional care towards community care. By the beginning of the 1980s, little progress in achieving such a shift had been made, and recent reports in the late 1980s suggest that subsequent progress has also been slow.

Analysts have given various reasons for this failure, but this study is founded on the proposition that professionals in the organisations responsible for the delivery of care to the 'priority' or 'dependency' groups are likely to have played a significant role in the only *partial* implementation of the policies. It reviews literature on theories of social policy development, organisational behaviour and the role and

significance of professionals in organisations, arguing that the beliefs and attitudes of professionals may amount to what can be called ideologies which condition and mould behaviour.

The study is based on extended, semi-structured interviews with 236 respondents in three Scottish locations. It finds that distinctive patternings of attitudes emerge according to professional affiliation; other factors, however, also exert a conditioning effect - such as organisational position, agency membership and the practitioner/manager distinction. Attitudes directly relating to the policies themselves are moulded by the significance which the issues hold for the respondents concerned - thus a dichotomy between the abstract and the concrete emerges. Although support for the policies *in principle* is usually forthcoming, it tends to be couched in equivocal terms. The study concludes that such ambivalent attitudes are likely to play a major part in shaping the outcomes of the policy process.

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BELIEFS, CULTURE AND CIRCUMSTANCE: A CRITICAL EXAMINATION OF THE CONCEPT OF PROFESSIONAL IDEOLOGY IN RELATION TO THE HEALTH AND SOCIAL SERVICES

INTRODUCTION

During the 1970s and 1980s a series of policy documents was produced by central government which pointed to new priorities being established in the health service and, to a less clear extent, in the personal social services. The priorities related to particular patient and client groups and required associated shifts in patterns of resource allocation to underwrite them. The first of these policy developments followed major and radical changes in the structures of the health service, local government and the social services; during the subsequent period as policies have been further developed, modified or refined, there have been further structural changes - at least in the health service - and others are mooted.

The priorities were established over a decade ago but it is generally recognised that progress towards achieving them did not meet original expectations; the position of the client groups involved did not greatly ameliorate during that time although some development did take place, albeit on a somewhat patchy and piecemeal basis. In seeking to explain this lack of progress, a number of questions are raised: how far was that lack of improvement due to deficiencies within the organisations responsible for service delivery to the client groups in question - deficiencies perhaps in some way related to the upheavals

of reorganisation, or inherent in their planning and implementation systems. Or was the lack of success due to professional resistance on the part of those charged with responsibility for the implementation of policy at the 'front line'? How far was it due to a lack of support at the highest levels of government and civil service? Or was it due to a reluctance on society's part to support a shift of emphasis from one set of priorities to another? To a great extent, these must remain open questions, since they are clearly too large to be answered by a single study. But it is necessary to recognise that explanations are likely to be complex and that the results of one study alone can only offer partial clarification.

The study

The study outlined in this thesis is concerned with examining one set of factors which bear on the establishment and implementation of policy - namely, the role and influence of professionals in the policy process. It is based on a central premise which argues that the competing interests of professional groups involved in the delivery of care, treatment and services, in both the health and personal social services, are likely as much to impede, constrain or modify the rational implementation of policies as they are positively to facilitate it, especially those policies conceived at higher levels removed from the arena of professional practice.

The present study was part of a wider programme of research concerned with the way in which social responsibility is allocated for the care

of chronically dependent people (hence the naming of the priority groups in this study as 'dependency groups'). The overall concern of the programme started with a philosophical question about how society as a whole arrives at decisions relating to the care of its sick, disabled and dependent members; it was concerned with the inter-relationship of the roles of state, family and the individual in the allocation of this responsibility. In concrete terms, it sought to examine decisions about the allocation of resources and the attitudes surrounding the processes of resource allocation. There were three components to the programme. One study was concerned with assessing public attitudes to the major questions; the existence of a distinctive public opinion in relation to the policy issues might, it was argued, be a significant contributing factor to what may broadly be called 'the climate of the times' - and, hence, play a part in setting the broad policy agenda. The second study was concerned with examining the playing out of the decision-making process as it involved the policies under scrutiny - at health board and local authority social work department level. In this way, it was hoped to document the factors which influenced policy implementation and to identify some of the constraints and barriers which operated on decision-makers in their attempts to put policy into practice.

The third component in the programme - the study reported in this thesis - was concerned with exploring the views of those same decision-makers and practitioners - namely, those actors who were faced with the responsibility of turning policies into operational reality and of providing care and treatment according to those

policies. It sought to identify any patterning of views there might be - according to profession, position and location, for example - which might be termed 'ideological' which would have some bearing on professionals' readiness or ability to implement policy as conceived by higher level policy-makers. It concentrated, then, on attitudinal variables rather than on behavioural aspects - the latter being the concern of the second study.

The three components stood as discrete studies in themselves, posing questions and seeking answers to them independently of each other. Nevertheless, it was also hoped that at the same time they would inform each other *and* answer some of the broader questions underlying the whole programme. Some questions, then, inevitably arose from within one study which could only be fully answered by reference to the whole programme; they cannot, therefore, be fully considered here (the direct relationship between views and behaviour, for example).

The study was conducted in three Scottish locations, representative of urban settlement in that country: a large conurbation, a medium-sized city and a small rural town. A sample of professionals was interviewed across the three locations within health and social work settings - from the most senior managers down to junior levels of administration, and including practitioners such as social workers and GPs. Respondents were asked a series of questions ranging from views about specific policies, issues to do with day-to-day practice and the broader moral questions about social responsibility in general. It was hoped in this way to establish attitudinal profiles of all the

various groups involved in the study out of which might be drawn patterns of significant variation for analytical purposes.

The organisational context

The past twenty years have seen a series of major organisational changes affecting the health and personal social services in the United Kingdom. The development of policies for the dependency groups has taken place within this changing organisational environment. The first of the changes was proposed as far back as 1968 in Scotland and 1970 in England and Wales and related to the personal social services. As things stood, a variety of different departments were responsible for the delivery of services - there were divisions between child care officers, mental welfare officers, medical and psychiatric social workers - both in terms of professional identity and employing department. In line with the recommendations of the Kilbrandon Report (for Scotland) (SHHD/SED 1964) and the Seebohm Report (for England and Wales) (Great Britain. Committee on Local Authorities.... 1968), generic departments were to be set up, within local authorities, to avoid the unnecessary (as it was argued) compartmentalising and categorising of social welfare problems. The debate between genericism and specialisation had begun.

Local government reorganisation followed in 1973 and set up 2 tiers of authorities, with functions divided between the two - social services and education, for example, going to the higher tier of the Region in Scotland and the County in England and Wales (except in those areas

designated Metropolitan areas), and housing going to Districts. Functions which had previously been the responsibility of the old local authority health and welfare departments were now taken out of local authority hands and handed over to the health service (district nursing, health visiting and the ambulance service).

Other major structural changes have involved the health service. In 1974, the new NHS Act integrated hospitals and community health services into one administrative unit. The 625 different bodies (DHSS/PSSC, 1978) which had run the NHS up till that point (mostly hospital boards of management) were abolished and administration was organised on a geographically defined basis, co-terminous as far as was possible with local authority boundaries. And just as local authorities had passed over responsibility for certain community health services, now the local authority took over responsibility for social work within hospitals, clinics and general practice. There were further major changes in the 1980s; in England a whole tier of administration was abolished - the Area health authorities - and services within Districts (England) and Boards (Scotland) were reorganised on a sectoral, or unit, basis; this marked the emergence of separate Units for the running of different aspects of the service - most commonly for the acute, community, and priority groups services. This was followed a year later in 1983 by the Griffiths Report (DHSS, 1983) which called for the old system of consensus management to be replaced by the introduction of general management (a single chief executive at each level of the structure - Unit, District or Board, and in England, Region, with over-riding decision-making responsibility).

The health service has been coming to terms with the introduction of this form of management since that time.

The dependency groups

The priorities which are the focus of this study were drawn up shortly after the first bout of reorganisations had taken place - that is, in the mid-1970s. They marked the first explicit attempt within the health service at establishing comprehensive priorities relating to particular patient groups. There had been earlier attempts of a sort at setting a national strategy but these had been concerned primarily with the planning of capital expenditure on hospitals (Great Britain. Ministry of Health, 1962). Under the new proposals, certain categories of patients - defined by the long-term nature of their dependency, their lack of response to curative treatment and their tendency to fall under the responsibility of both health and local authority service systems - were expected to be given greater priority in operational terms and strategic planning. In addition, greater emphasis was to be placed on community rather than institutional forms of care.

A series of documents (to be examined in Chapter 1), some concerned with particular patient groups and others concerned with the planning of priorities within the overall context of the NHS, were published underlining this new emphasis. However, even as early as 1979 (just three years after the main priority documents had been published), the Report of the Royal Commission on the NHS (1979) was pointing to

difficulties in achieving the newly established objectives. It could, of course, be argued that three years was too a short a time for any realistic judgement about success or failure to be made. Nevertheless, the subsequent publication of a number of other reports tended to reaffirm the Royal Commission's pessimistic assessment, at least in part. The Scottish priorities document for the 1980s, SHAPE (SHHD, 1980), stressed the need for greater commitment to the priorities; other reports in the mid-1980s came to the conclusion that insuffucient progress had been made (Great Britain. Parliament. House of Commons, 1985) although some recognised that while progress at an overall level had been disappointing, some achievements had been made - but generally on a small scale at the local level (Audit Commission, 1986; DHSS, 1988a [Griffiths Report]). But the most recent Scottish policy document, the SHARPEN report (SHHD, 1988), continues to emphasise *lack* of progress and calls for greater effort.

The pattern of failure or, at most, slow progress has been accounted for in a variety of ways. According to the Royal Commission, failure to implement plans could be put down to a number of reasons: it suggested that the lack of objective criteria on which priorities could be based meant that decision-makers at the centre had difficulty in assessing advice and pressure that came from the periphery and from a variety of perspectives. The array of competing interests (centre/local; inter-professional; lay/professional; inter-departmental) all impinged on decision-making processes in a complex and confusing way. Further, the resource consequences attached to the priorities had not been fully taken into account; implementation was difficult because

expected and anticipated resources were not forthcoming from other sectors.

The Audit Commission published in 1986 lists a number of predominantly structural factors: fragmented organisational arrangements create delays and difficulties, mechanisms for transfer of funds from hospitals (run by the health service) to the community (under local authority responsibility) are unsatisfactory, bridging finance to enable community services to be built up while in-patient facilities are run down is inadequate and the recruitment and/or retraining of staff to work in the community has been insufficient. The Griffiths report on community care published shortly after the Audit Commission's report endorses its conclusions and uses them as a starting point for its recommendations (largely about the need to develop local services tailored to meet individual needs under the lead responsibility of a single agency).

Other sources have emphasised slightly different reasons. In his discussion of mental health services, Martin (1984) suggests that there has been a lack of 'imaginative awareness' about the realities of mental illness and the care requirements of mentally ill people. He argues that the service norms proposed in the mid-seventies policy documents were pulled out of the air and not based on any realistic assumptions or calculations. He further stresses the need for enthusiastic championing of both the interests of the mentally ill and the development of appropriate policies for their care; otherwise

success will be hard to come by. Changes in professional attitudes and behaviour are also essential.

In Scotland, according to the most recent policy document (SHHD, 1988), health boards and local authorities have been slow to produce joint plans for developing community care; in spite of a constant re-statement of the policies, there has been a general lack of will to proceed. It argues for a client-based rather than a service-based approach as has usually been the case and stresses the importance of strong leadership, with a focus on action rather than structure as a means to success. Surveying the evidence, then, from a range of reports and studies, there is thus a widespread view that the priority policies have not had the success anticipated when they were first produced.

But the question of failure is complex. First, it can be argued that the policies have not 'failed' - rather, they have been implemented in a variable, incomplete and unsystematic way: there is evidence of innovation and development in some areas on a small-scale basis as well as evidence of little change or progress in others. Second, a distinction should be made between the progress of implementation in England and Wales and in Scotland.

In the case of the patchiness of implementation, Hunter and Judge (1988) have argued that the amount of innovation that has taken place has been underestimated. For example, the Welsh Office policy on services for the mentally handicapped (Welsh Office, 1983) is clear

and imaginative; the community care initiatives devised and monitored by the PSSRU at the University of Kent in conjunction with a number of social services departments have had considerable impact (Davies and Knapp, 1988). In some cases closure of long-stay hospitals is proceeding on a carefully planned basis with a number of health authorities developing networks of associated community-based alternatives (Exeter District Health Authority, 1986). Hunter and Wistow (1987) stress that there are important influences which affect the success of such policy initiatives; these include the extent to which developed service infrastructures exist, the spending patterns of the relevant agencies and the pressure of interest groups. The interplay of these and other factors is likely to affect the degree to which the policies are implemented; some agencies and authorities have had greater success than others. Thus the debate about the relative extent of success and failure of the policies is unresolved.

The distinction which should be made between the development and implementation of policy in Scotland in contrast to that in England and Wales is an important one. A number of analysts have drawn attention to the different historical traditions which have influenced the structure and content of policy-making in the respective countries. Hunter and Wistow argue that the hospital sector has traditionally dominated the Scottish health service more than in the other two countries and that this has had consequences on the pattern of provision for the dependency groups. Similarly, they argue that there were significant differences of emphasis in the policy documents published in Scotland relating to the dependency groups as compared

to those for England and Wales; custom and practice within the relevant central departments in each country have influenced the style and content of the policies produced. This has had major implications for the development of operational policies at local level.

These points are also made by Martin (1984); there is no doubt in his view that the policies have been a striking failure in Scotland (at least in regard to mental health policy). Amongst other things, he stresses the failure of local authorities to make provision for the dependency groups, partly due to the fact that they had many other responsibilities - such as the probation function and a new juvenilew justice system - to administer. He also argues that the 'support finance' system in Scotland (for sharing and transferring responsibility between health and social services) was less effective than its counterpart south of the border. But other important factors which he highlights have more to do with a difference in underlying 'professional and administrative' attitudes to the issues. He suggests that in Scotland there has been 'an excess of complacency and a lack of self-examination both in the central department and in the relevant professions' towards the issue of community care.

Martin's stress on attitudes as a key factor in the Scottish response to the priority policies has a special significance for the study described here. The central proposition on which the research was based, as noted above, was that the role of professionals - in terms of their behaviour ***and*** attitudes - was likely to have a constraining

or modifying influence on the playing out of the policy process. As will be demonstrated in the findings, professionals interviewed in the study displayed mixed and sometimes lukewarm views about the policies; in this they lend weight to Martin's assertions about the significance of the failure in the Scottish context of professional commitment. Professional attitudes, however, were not found to be uniformly hostile; they were characterised by a fluidity of views - the product of a wide range of influences, both abstract and concrete. Such variability, it can be argued, matches (and relates to) the variability of policy implementation. Indeed, a central conclusion of this study is that the wide spread and variability of beliefs and attitudes amongst the actors involved is a significant likely factor in explaining the patchiness and piecemeal nature of policy success - and is thus particularly relevant in considering the contrast between Scotland and the countries south of the border.

The plan of the thesis

In the opening chapter of the thesis, some current theories of social policy analysis are examined in order to demonstrate the 'ancestry' of the conceptual framework within which this present study is based. An attempt is made to show the degree of difficulty which writers have found in trying to account for the development of social policy, especially in trying to answer the question 'why the perception of particular social issues and the development of particular policies at particular times?'. A framework for examining the process of policy development is constructed within which this study can be located -

looking at the relative merits of functionalist, pluralist and marxist perspectives and the possible ways of explaining how and why certain issues appear on the policy agenda. This is then followed by a review of the relevant policy documents to demonstrate the intentions of central policy-makers over the past two decades in relation to provision for the care of the dependency groups.

The policy review is followed by a chapter looking at the literature on organisational theory - especially insofar as it relates to the importance given to the role of professionals within organisations. Broadly speaking, a phenomenological perspective is advocated in order to allow due weight to be given to the part played by professionals. Their role and its influence as it has been accounted for in the literature is then examined. In addition, writing on professional ideologies is considered in order to judge how far the propositions upon which the current study is based are supported by evidence from earlier studies. It was decided at the outset to locate the analysis in the body of theory relating to professionals in organisations and to professional ideology. It was recognised that the subject of the research touched on a number of contrasting research perspectives - the sociology of the professions and professionalism, management theory and management studies, and theories of organisational behaviour, for example. However its central emphasis was on the significance of the influence which professional beliefs and attitudes might have on the policy process. For this reason a theoretical framework which offered insights into the relationship between beliefs, behaviour and organisational action was regarded as essential;

thus theories about the construction and patterning of professional views (in terms of ideologies, stereotypes, operational philosophies and so on) were favoured, as were phenomenological approaches to the analysis of organisational action in which the importance of individual actors was recognised. Such an approach, it was felt, would offer a distinctive contribution to the wider field of policy analysis.

These preliminary chapters, then, provide the theoretical context within which evidence from the present study can be situated. They are followed by a section on propositions, aims and methodology. It describes how the study was set up and outlines the structure of the interviews. Problems of how analysis was organised and accomplished are discussed.

The following two chapters are devoted to a presentation of the findings. First, a series of profiles of all NHS professional groupings under study are presented; second, is a chapter covering profiles of three social work groupings. This is then followed by chapter six which looks at other significant means by which the data can be analysed. Initial propositions suggested that professional allegiance, geographical location and professional definitions of need were likely to be important factors in determining attitudes. In the light of further analysis a number of other, cross-cutting, factors are shown to be equally significant.

In chapter seven, a threefold framework is devised which, it will be argued, provides an explanation of the diversity and variability of professional views; it argues that differences are not only ideological, they are influenced by factors of circumstance and culture too. Ideology, however, remains a significant and central explanatory concept. Overarching abstract or 'ideological' views may be mediated by concrete experiences which conflict with them. Boundaries drawn by cultural or 'tribal' allegiances may prove more binding to those within them than either the weight of the abstractions of ideology or the concreteness of circumstance. In relation to policy implementation and the expectations of central policy-makers, the mixed and various expressions of professional attitudes are complex and often unpredictable.

It is perhaps, as suggested earlier, this complexity and unpredictability which is significant in explaining the variability and uneveness of policy implementation. While priority policies have been slow to achieve widespread or consistent success, there have been innovations and developments on a piecemeal basis. A model which characterises professional beliefs and attitudes as being conditioned by a wide range of influences, both abstract and concrete, and which stresses variability and the significance of context is also a model which can accomodate patchiness and variability in policy success. In such an environment, success depends on the opportunistic seizing of initiative wherever and whenever possible. The beliefs and attitudes of actors involved in policy implementation are likely to play a significant part in the process.

The final chapter sets the findings of the study in the broader context of current policy debates. Policy-makers in the centre have expressed concern over the failures of implementation. There has been a rush recently to overcome this by proposing further structural or procedural change in many fields of government policy, but especially in respect of the health service. Stress is placed on the need for greater collaboration between agencies and between professions; faith is proclaimed in the efficacy of rational management. But the evidence that emerges from this study is that actors in the decision-making and operational processes may - either intentionally or unintentionally - confound these exhortations and expectations. The construction of their ideological beliefs and views is complex; the patterning of their attitudes to particular policy issues may be built on the cross-cutting of competing influences and motivations. Actors at the local level of the policy process are a significant force to be accounted for, although the precise nature of their significance may be unpredictable. This study argues that without a better understanding of the nature and construction of professional views, any future policy developments will be as unlikely to achieve substantive change as have policies in the past.

CHAPTER ONE

THE DEPENDENCY GROUPS AND THE DEVELOPMENT OF SOCIAL POLICY

A. THEORIES OF SOCIAL POLICY

Policies giving priority to a number of patient groups - characterised by their need for long-term care and their lack of susceptibility to curative treatment - were developed within the framework of health and personal social services planning during the 1970s. The patient groups in question were the elderly (both the frail and confused), the chronically sick and physically disabled, and both mentally ill and mentally handicapped people. While it is a relatively straightforward matter to outline the sequential development of these policies, it is a great deal more difficult to explain why these policies were introduced in the first place.

The official documents rarely give any clues as to why a particular policy has been decided upon; they simply state that this is so. They may give some justification: in the case of the elderly, for example, the rapidly increasing numbers of the very elderly is sometimes cited (DHSS, 1976a, para 5:2) and in the case of statements calling for more community care for the mentally ill, the cost is mentioned (ibid., para 8:14). This does not, however, explain why policy-makers at a given time adopt one policy rather than another. However major a problem may be, there is usually evidence to show that scale alone is never a

sufficient cause for action; a variety of other factors have to be recognised before acceptance is given by placing a particular problem on the policy agenda.

The tendency, however, at the official level is to allow the emergence of social problems and the quest for their solution to be seen as the outcome of some sense of 'natural justice' combined with administrative rationality. This is certainly so in the case of the dependency groups. It seems to be assumed that other sectors in the past have had precedence (notably the acute sector) and now it is both fair and efficient for the neglected sectors to take priority. It is, of course, questionable that policy-making is ever as rational or common-sensical as this; indeed, the Royal Commission on the NHS, reporting in 1979, concluded that current priority setting was 'not the result of objective analysis but of subjective judgement' (para 6:61). It went on to recommend that the 'health departments should make public more of the professional advice on which policies and priorities are based (para 6:7).

The influence of historical antecedent, perceptions of current needs, competing interests, ideological position and assessments of the feasibility of implementation are all likely to be significant factors bearing on decisions made by government departments. Underlying most of these will be sets of values and assumptions that may or may not be made explicit. However, any explanation of policy development is problematic and there are a number of schools of analysis which differ in their interpretations of the process.

Schools of social policy analysis

Broadly speaking, there are four modes of interpretation. A traditional one, and one which is commonly criticised, is the one which sees the development of social policy in western society as the outcome of a cumulatively beneficial process, often linked with the actions of 'great men and women'. Underlying it has been a view that once needs are revealed and solutions proferred (through reliance on a careful gathering of facts and the dissemination of illuminative information), appropriate and benevolent policies will be forthcoming. Social policies leading ultimately to the establishment of the 'welfare state' were, according to this view, the result of 'far-sighted visionaries or humanitarian reformers, concerned to neutralise so far as was possible the harmful effect of industrialisation in the nineteenth and twentieth centuries' (Gough, 1978).

This general view is implicit in much of the literature: Penelope Hall's outline of the social services (Hall, 1952) emphasises the achievements in social reform of Lord Shaftesbury, Octavia Hill, Edwin Chadwick, Dr. Southwood-Smith and so on. In accounting for developments in education, medicine and, especially, maternity and child welfare services in the nineteenth century, Slack (1966) suggests that reforms were introduced once the deleterious effects of ignorance and poverty were revealed and the evidence of the high maternal and infant mortality rates was demonstrated. Robson (1976) interprets the development of the welfare state as the outcome of the 'shock and remorse' felt by the middle and upper classes at the

revelation of the appalling poverty suffered by those at the bottom of the social scale.

This school of thought would argue that Bismarck's introduction of social insurance in Germany at the end of the nineteenth century was a benevolent act of social progress; the introduction of rent controls in Britain during the first world war is interpreted as a measure of social justice at a time when all members of society were co-operating equally in the war effort. (Critics however would argue that Bismarck was 'buying off' a discontented working class and that rent controls were introduced to pacify militant working class protest, especially on Clydeside) (Hall, Land, Parker and Webb, 1975). The 'social conscience theory' discussed and criticised by Baker (1979) adopts this benevolent mode of interpretation; Baker argues that it is characterised by a number of features: social policy is evolutionary; it is progressive; all benefits are cumulative and are based on increasingly deeper and broader knowledge; and contemporary social provision is the highest historical form.

Other approaches, too, in the analysis of policy development see it as a largely benevolent process: functionalists, for example, would argue that change comes about because it is necessary for society's continued smooth functioning; they might suggest that society's needs develop over time and when the optimum moment of need has been reached, change is precipitated (although they rarely explain how) to ensure satisfaction of those needs (measured in terms of equilibrium/disequilibrium). Conflict, when it occurs, is seen as a

ritualised expression of the interplay of social forces, which in itself contributes to overall social cohesion (Gluckman, 1963), (the function of 'Her Majesty's Loyal Opposition' would be a good example), or as the building up of a set of dysfunctions which then leads to a readjustment back to 'balance' (Merton and Nisbet, 1965).

Underlying many interpretations of social policy development is a notion of evolutionary process - although the early functionalist anthropologists (Radcliffe-Brown and Malinowski, for example) constructed their theories as rebuttals of the social evolutionist approaches of nineteenth and early twentieth century speculative writers (Cohen, 1968). The apparently static nature of the small-scale societies that anthropologists studied led early ethnographers to believe that their social systems were structured on the basis of harmonious, functionally inter-related and inter-dependent parts. For sociologists, working in historically-defined and -described societies, the obvious processes of change and development had to be accounted for.

Functionalist sociologists have seen change as the necessary response to socially produced imperatives (Gough, *op.cit.*). Fraser (1973), for example, suggests that social policy:

> comprises the community's response to the practical needs of society as a whole [and] the Welfare State is subject to those same evolutionary forces which were its ancestors. The Welfare State was thus not a final heroic victory after

> centuries of struggle but the welfare complex of a particular period adapting to the needs of the next generation.

And Titmuss, though more often adopting an eclectic theoretical position, and not usually regarded as a functionalist, is quoted by Hall *et al* (*op.cit.*) as saying:

> all collectively provided services are deliberately designed to meet socially recognised "needs", they are manifestations of society's will to survive as an organic whole. (Titmuss, 1958)

Attempts to account for the part played by conflict or competition and to see social policy as an outcome of a conflict of interest characterise the third broad approach - the pluralist approach. Power is seen as diffuse and dispersed *non-cumulatively* throughout society. Consequently no single group is ever continuously dominant. Thus the wielding of power is seen as the product of a series of shifting coalitions (Gough, *op.cit.*). A corollary of this view is one that sees a fundamental consensus about the ultimate cohesion of the system as underlying this negotiation or skirmishing. Thus there can be no radical, structural cleavage that *permanently* divides society. The classical pluralist view is proposed by Dahl (1959). Society is composed of a wide number of legitimate interest groups and these

> aggregates all have an impact on policy outcomes;..... none of these aggregates is homogeneous for all purposes;.... each of them is highly influential over some scopes but weak over many others.

The state in this schema, according to Miliband (1974) who criticises the pluralist analysis, is seen as sanctioning and guaranteeing competition between interest groups and as ensuring that power *is* diffused and balanced. In spite of critics such as Miliband, Hall et al (*op.cit.*) argue that on the face of it the pluralist position apparently resembles 'real life' political experience and therefore cannot easily be discounted (although they go on to acknowledge that the 'systems' approach to policy analysis which they find attractive is not able to take into account those interests which are not in contention - in Alford's (1975) 'the repressed structural interests').

Class analysis and specifically Marxist analysis, however, criticises the pluralist view fundamentally for failing to recognise that amongst the blocs of interest in society, there is one set of interests which predominates consistently and that society itself is constructed on the basis of that fundamental division of superordinate and subordinate interests. But at the same time a Marxist writer such as Gough (*op.cit.*) may applaud the pluralist approach for attempting to take into account mens' actions in the analysis of power and policy while condemning functionalism for its over-deterministic view. However, Marxist analysis itself is frequently criticised for being overly deterministic.

Ironically, Marxism can be seen as exhibiting elements of all three of the theoretical schools it seeks to displace: the progressive, developmental element (a characteristic of historical materialism) is also associated, in a contrasting way, with the 'social conscience'

school; a focusing on the objective determinants of human history (the laws of development operating independently of people's consciousness and intentions) is reminiscent of functionalist determinism; but at the same time the importance of stressing the subjective content of human action ('the creative role of mankind' in history) is not too far removed from the action-oriented approach of the pluralist school.

Whilst each of the schools outlined above presents problems which cannot be satisfactorily resolved at the level of grand theory (Mills, 1961), there are elements which both functionalists and Marxists might accept which can be welded into a workable middle range theory - which is the course taken by Hall et al (their 'middle or lower order generalisations'). Thus we may accept the view that the adoption and development of policy is the outcome of a series of struggles between opposing views and interests (which may or may not - according to theoretical stance - be based on a fundamental class-based structural division). But in order to get beyond this unsubstantiated proposition, the operation of these forces has to be *demonstrated*. It is perhaps not surprising that this is the juncture at which Marxists and action-theorists meet in opposition. The former suggest that for pluralists each act of policy is:

> theorized as a unique event determined by the particular constellation of interest groups concerned. Hence this cannot provide a *general* theory to explain the growth or structure of the Welfare State . (Gough, *op.cit.*)

The latter, on the other hand, suggest that however convincing the Marxist view may be at the theoretical level, it never moves beyond the stage of assertion. There have been few attempts by Marxists to analyse specific pieces of policy development in detail. Nevertheless, neither school would deny the operation of conflicting interests in the field of social policy, and both would see policy as an outcome of this conflict. Dispute lies, however, in the structural significance given to these competing interests.

This present study cannot seek to present a case study in social policy or hope, in the process, to demonstrate the operation of competing interests (in whatever tradition); rather, it takes that competition of interests as a basic premise and seeks to look at one component of that competition - namely, the force of professional attitudes as a factor in the negotiation of policy and its implementation.

The priority policies

But if social policy emerges over time from a continuing process of competitive interests, the identification of 'process' does not in itself explain the specific content of that process. Why, for example, in the policy under study here, did the elderly, mentally ill and physically and mentally handicapped come to be identified as worthy of special consideration in the post-Beveridge period, especially after

1970 (and yet, as much of the evidence shows, with relatively little success).

The policy documents themselves do not profer any explanation, except to suggest by implication that it might have something to do with the increasing numbers of very elderly people and the high cost of hospital care for the mentally ill. They do not account for the reason why these specific groups came to be given greater value in the notional allocation of health and social service resources during this period nor why they had been comparatively neglected during earlier periods.

A number of explanations have been offered. One is the straightforward demographic explanation: 'pressure of numbers'. Many of the policy documents are prefaced with an account of population projections in relation to the patient group in question (usually the elederly) and, by implication, this is proferred as explanation. Other sources (Walker, 1982) regard the factor of numbers as one of several inter-related reasons. Illsley (1981) sees the patient groups in question as displaying a set of common characteristics which can thus be seen to place them in a single category. He suggests that they are all resistant to curative treatment; they are all potentially costly as long-term users of health and social services; they come within the responsibility of more than one profession or service organisation; and they are all economically unproductive and thus socially and economically dependent.

This unitary categorisation does not, however, explain the reasons for their being given priority. Indeed, with so little in their favour given these demonstrated characteristics, it may be thought surprising that policy-makers chose to favour them at all. Illsley suggests that there are a number of reasons for the 'dependency groups', as he terms them, to emerge as a recognised social problem which policy-makers were prepared to take account of. First among them are indeed the demographic factors mentioned earlier. Success in the control of epidemic disease, better nutrition and hygiene, along with effective treatment of the diseases of old age, such as bronchitis and pneumonia have all ensured larger numbers of the population surviving into an older age. In addition, changes in the birth rate and postponement of the age of first earning (through prolongation of education) have led to an imbalance in those of productive status and those of non-productive status. Greater mobility, more women at work and urbanisation in general have led, according to Illsley, in the ability of family and community to support dependent people. Increased expectations of higher standards of living and care lead to greater pressures on resources. Other reasons which have been posited are related to innovations in medical knowledge and technology which have led to the survival of more congenitally- or accident-damaged individuals. Further, it is argued, because of the power of the medical profession and certain segments within it, an imbalance in the allocation of resources has occurred so that certain patient groups (the dependency groups in particular) have suffered as a consequence.

For Illsley, these are long-term structural movements which have great explanatory value. But he also recognises that they do not offer a complete explanation. He points out that the recognition of certain issues or certain categories of the population shifts over time, citing the different groups which dominated policy debate in the 1960s and early 1970s (for example, institutionalised offenders, unmarried mothers, abortion-seekers and ethnic minority groups). These groups, he argues, have been far less prominent in policy debate since that time. He suggests that 'economically induced' ideologies generated by the economic climate of relative optimism in the 60s and early 70s contrasted with one of depression after that time have played a great part in influencing policy.

Differing explanations have been offered by other writers - in the case of concern for mentally handicapped people, the discovery of the appalling conditions experienced in a number of long-stay mental handicap hospitals is frequently given as the explanation for the development of that concern (DHSS, 1971[a]). Some suggest that policy changes came about as the direct result of research, citing Townsend's (1962) and Goffman's (1962) work on institutions and their deleterious long-term effects. The movement for de-institutionalisation can be seen, according to this view, as an essentially 'intellectually' derived concern. which has then been adapted by policy-makers, perhaps for their own (cost-cutting) ends. Pragmatic interpretations centre on the pressure of increasingly high costs being the motivating force for policy change - especially the costs of running large long-stay geriatric, mental illness and mental handicap hospitals. (The

contrary argument - that community-based care is likely to prove equally as costly is not confronted).

This variety of interpretation raises the key problem of how social problems emerge, or *fail* to emerge as policy concerns, but does not provide the answer. Blumer (1971) criticises sociologists in general for failing to study the process of the emergence of social problems. In particular, he criticises a common sociological approach which locates social problems merely in objective conditions; he argues that this approach is deficient for a number of reasons. First, it fails to detect or identify social problems; second, in trying to reduce a social problem to objective factors such as rates of incidence, numbers and types of people involved and their social characteristics, the sociologist fails to recognise that it is 'societal definition' that determines whether a condition is deemed to be a social problem or not. Thirdly, there is an assumption that once society is made aware of the existence of a problem (defined by recourse to the objective facts), remedial treatment can be effected.

Blumer emphasises the need to regard the emergence of social problems as the outcome of a process of 'collective definition'; he gives examples of certain issues which have persisted over time but which have only been recognised as 'social problems' requiring solution at certain points - the conspicuousness, submersion and reappearance of poverty during this century; the relatively recent recognition of racial injustice in the USA; concern about women's inequality are all

examples of issues that have existed for many decades, but have only come to prominence at particular times.

Blumer goes on to identify five stages in the process of collective definition: societal recognition, legitimation, mobilisation of action, an official plan and implementation:

> it is this process which determines whether social problems are recognised to exist, whether they qualify for consideration, how they are to be considered, what is to be done about them and how they are reconstituted in the efforts undertaken to control them.

He argues that there is 'pitifully limited' knowledge about why society chooses at any one time to focus on one particular set of conditions and regard them as a social problem. It is too much of a sociological platitude to say that perception of problems depends on ideologies or traditional beliefs without demonstrating why or how this should be so.

Many other writers (Manning, 1985; Becker, 1963; Haines, 1979) stress the distinction between objective conditions and subjective perceptions as being significant in the determining of social problems - such subjective interests may be determined by sectional factors, the mass media, the outcome of tendencies in society at large to 'victim blaming', the need to render problems as technical and apolitical and so on. Many of their arguments are persuasive but there have been few systematic or empirical analyses which have demonstrated the validity of these approaches. They do, however, contribute to the

building of a framework within which to consider the general problem of studying priority-setting in relation to the identification of social issues; further, they support the approach which suggests that policy is the outcome of a series of struggles between opposing views and interests, located in an ever-shifting set of values about the relative worth of particular social groups and conditioned by the 'economically induced' ideologies of particular periods - recognising, however, that the range of interests incorporated in the policy struggle may well be partial and unequally weighted.

That the definition of problems and the identification of 'worthy' client groups changes over time is not in doubt. The treatment of the elderly and the chronically sick during the past hundered years provide such an example of how relative values change over time. At times, the elderly and the sick have been seen as deserving of societal support (in contrast especially to the able-bodied unemployed), but at other times and for other reasons they have been seen to be less attractive than other groups in society. Pinker (1971), for example, in his account of the functioning of the Poor Law in the nineteenth century, shows how the workhouses gradually filled with chronically sick people either displaced or excluded from the voluntary hopsitals. These hospitals were developing as centres of curative medicine, of teaching and research, and patient groups which did not respond to curative treatment were not attractive to them. Similarly, during times of war, the elderly and the chronically sick are less valued than 'potential effectives': Means and Smith (1983) describe how, in the planning of hospital facilities to cope with the

the effects of possibly heavy civilian injuries during the second world war, the elderly and chronically sick were expected to take second place to those who could be restored to full capacity.

Thomson (1983), in his study of residential care for the elderly since 1840, reviews the economic position of the elderly over the past one hundred and fifty years and demonstrates how their position has improved and then deteriorated several times during that period. From a relatively comfortable position supported by adequate Poor law pensions around 1840, the implementation of the new Poor Law brought about a savage cut in scope and levels of income support. This was improved after the Old Age Pension Act in 1908, but in the post-1945 period, Thomson argues that standards have fallen proportionately again. These patterns of fluctuation seem to bear some relationship to wider social attitudes towards the elderly.

Currently, for example, Wilkes (1981) suggests that the elderly and other chronically dependent groups are unpopular with social workers because professional emphasis is placed on effecting change and improvement. Working with groups where there is little hope of future improvement is regarded as professionally unrewarding. The client groups involved, suffer a consequent loss of social worth. This is, of course, reminiscent of the attitudes prevalent in the nineteenth century within the voluntary hospitals sector.

Nevertheless, there are contrary valuations. Notions of 'deservedness' and 'undeservedness' have characterised social policies over the centuries. While the elderly suffered in the latter half of the nineteenth century, the greater victims were the able-bodied, younger poor. The new Poor Law, with its rule of 'less eligibility' and policy of requiring recipients of relief to enter the workhouse, was quite clear in its categorisations of the deserving and undeserving poor. Although the elderly were badly treated in the latter half of the century, they were better off than their younger, able-bodied brethren (Smith, 1984).

Similarly, in the 1980s, a distinction has emerged which suggests that the elderly and the chronically dependent sick and disabled are viewed by official policy-makers and planners more sympathetically than the able-bodied who are dependent on the state by virtue of their unemployment (Dalley, 1988)[a]. The decade has been characterised by a rhetoric which depicts the latter as feckless and as scroungers. In spite of a deteriorating economic situation during the 1970s and early 1980s when millions were forced unwillingly into unemployment, the abrasive moral climate of the times has emphasised sturdy self-reliance and the need for each individual to seek his/her own economic salvation. By contrast, those who are dependent through old age or sickness or disability are viewed much less harshly.

This may in part explain the shift in policy concerns noted by Illsley (*op.cit.*): that during the relatively affluent and optimistic economic climate of past decades, society was prepared to widen the

scope of the 'deserving' category in welfare to include the offender, the unmarried mother, the drug user, and so on. But by the late 1970s, as he notes, these groups no longer figured as major policy concerns. Instead, they had been replaced by medically-defined groups - the frail and confused elderly, the mentally ill, mentally and physically handicapped people and the chronically sick. Official policy, or perhaps the official rhetoric, of the period (or in Blumer's terminology, the official statement) has raised them to priority status; but what happens in practice is a different issue.

In trying to answer *why* this process occurs, analysts can describe the social, economic and political climate that gives rise to it. In doing so they have to take into account contemporaneous intellectual, ideological and moral attitudes and locate them within a conceptual framework which is alert to the structural divisions and interplay of competitive interests in society. But such explanation is problematic and most analysts tend to concentrate on describing how the process takes place rather than explaining why it does so. Blumer (*op. cit.*), as we have seen, suggests there are five stages in the process; Spector and Kitsuse (1977) outline four stages. First, they suggest a group asserts that there is a problem; second, there is an official response which is almost always ineffective; third, there is a restatement of the original assertion. Finally, there may be a feedback into the second stage with no effective outcome, or the original group which made the claim in the first place may take further action, either remedial action of its own or seek to change existing structures. This is very much a 'pressure group' view of

policy development and it is unclear as to how a claim is recognised as legitimate or not in the first place and how in the fourth stage alternative action becomes feasible.

Hall *et al* (*op.cit.*) propose three criteria against which the outcome of an 'issue' can be measured: legitimacy, feasibility and support. The degree to which an issue achieves priority will depend on its progress in establishing each of these. Other factors which must be taken into account are related to the characteristics of the issues themselves: for example, the 'scope and association' of the issue (how far it may be linked with other similar issues and how far it can be discretely defined); what part crisis plays in the emergence of the issue (whether it is an unintended consequence of some other key event or whether it is a demand resulting directly from a crisis such as a scandalous revelation); how far the issue can be seen as a preventive measure to avoid future crisis; what are the origins of the issue (by whom are they formulated - government or opposition - and the network of support available); how far an issue may be substantiated by accepted facts; and lastly what the 'ideological loading' of the issue may be (whether or not it accords with the prevailing ideology of the party in power).

By legitimacy, Hall *et al* mean whether or not action on an issue can properly be seen to be a function of governemtn. Feasibility, they suggest, is an elusive concept but relates to how far an issue can be practicably dealt with and by what means. Support involves what they define as 'locating the prevailing boundary of tolerable discontent'

and involves the notion of political trust and the stock or credit of a government.

It is clear, then, that they are mostly concerned with the process of social policy as it relates directly to government action. When they speak about the origins of an issue they are examining it within the context of the political arena rather than moving out into the wider social or moral arenas; when they speak of ideology, they are specifically referring to political party ideology. But Hall *et al* do not tackle the issue raised earlier which questions the way in which broad social attitudes towards certain social groups or social problems develop and change over time and which condition or determine the boundaries of legitimacy, feasibility and support within which government has to operate. Ideology, in the sense that conflict theorists might employ - namely, the patterning of beliefs, attitudes and values associated with a particular dominant social group which permeates all other groups, and conditions their attitudes too, regardless of whose interests it underpins - is not examined to show how it might affect the origins and development of broader social policy.

Nevertheless, it provides a useful analytical framework for examining case studies of social policy because it recognises the shifting elements of 'change, choice and conflict' that are at play in any social policy process once it has broken into political and public consciousness. Any official statements of policy can be usefully set

against such a framework. And in doing so, it is important to bear in mind that though current policy stresses the needs of the dependency groups, it is unlikely to have stemmed merely from revelations of those needs, or from a sense of natural justice and a consequent need to redress the balance of inequity. Evaluations of moral worth reflected in dominant ideological attitudes and the continual competition of interests amongst structurally significant groups may be equally important, though less easy to identify, as instrumental or influential factors.

If, as Hall *et al* argue, the meeting of the three criteria of legitimacy, feasibility and support is a necessary precondition for the success of a particular policy, it may be that in the case of the dependency group policies a failure to do so accounts for the apparent lack of progress in improving the position of the dependency groups. Indeed, one of the underlying suppositions upon which this present study is based is that it is likely that the policies will have failed to secure those criteria in the eyes of at least one set of interests in the policy arena - those of the professionals involved in working out operational policies at the local level and in their implementation.

It may be that the legitimacy of the claims of the dependency groups when measured against those of other patient groups has not been secured; or that the priorities are not seen as feasible when the other demands being made on the services are taken into account; or the policies did not gain sufficient support from all the differing

professional groups involved in terms of the degree of collaboration cutting across professional self-interest that would be required for success. In applying this approach to a study of professionals, it should be remembered, however, that the focus shifts away from the central subject of Hall et al's concerns - that is, government and governmental processes.

In the following section of this chapter, the official statements of policy are outlined and examined. It will then be possible to set the findings from the interview data presented later against this background to see how far any of these suppositions can be substantiated.

B. THE POLICY DOCUMENTS

The first statements conferring priority on the dependency groups were published in 1976, in Scotland, with the SHHD report *The Way Ahead* (SHHD, 1976) in England and Wales, with the DHSS report *Priorities for Health and Personal Social Services* (DHSS, 1976)[a]. This was the first time an attempt had been made to devise a national strategy within the health service which sought to rank particular patient groups in order of priority. Shortly before the publication of these reports had come the resource allocation document, the RAWP report (DHSS, 1976b), followed later by the SHARE report (SHHD, 1977), both of which aimed to redistribute resources equitably on a *geographical* basis at the level of health boards and health

authorities; this reallocation was to be based on population need as measured by SMRs (standardised mortality ratios), but was not targeted at particular patient groups.

The priority documents and the resource allocation reports emerged at a time characterised by an increasing concern felt by central government at the mounting costs of funding the health service and what was perceived of as the increasing public demand for health care. At the same time there was a sharp down-turn in economic growth which had repercussions for all parts of the public sector.

The proposals contained in the reports and documents were the first attempts at defining national strategies and targets in relation to the equitable distribution of resources. There had been, however, earlier reviews and assessments of policies and services, particularly in relation to some of the priority groups, but never on a comprehensive nationally-applicable basis. This might, it may be argued, be partly due to the facts of health service and local authority organisation up till that time. It was difficult to lay down integrated policies when health services were split between local authorities (responsible for community health services) , hospital boards of management and GP executive councils. There were too many decision-making bodies (625 in the NHS along with 150 local authorities). The reorganisation following the Local Authority Act 1972 and the National Health Service Act 1973 provided the opportunity for the establishment of national policies and priorities since the rationale behind reorganisation was that it would enable greater

coherence and structural uniformity to be established across the whole range of health services; a logical corollary was that this would also facilitate the development of nationwide planning.

The themes of better care for the dependency groups and deinstitutionalisation (the movement of patients from long-stay institutions to the community) can be traced back to the 1950s, especially in the case of the mentally ill. Gruenberg and Archer (1979) describe how a team of hospital directors from the United States visited Britain in the 1950s to inspect the transformation which they suggest had been brought about by three pioneer doctors (MacMillan, Rees and Bell) in the treatment of long-term psychiatric patients.

According to this source, long-term custodial care had been replaced by an 'open-door' policy where patients were given short periods of intensive in-patient treatment, followed up by long-term after-care. By 1954, half the case-loads of the three doctors were living outside the hospital - and this was before the introduction of psychotropic drugs which are commonly supposed to be the starting point for community-based care of long-term psychiatric problems. This effectiveness of this approach was suggested in the Report of the Royal Commission (1957) which preceded the Mental Health Act of 1959

and the Mental Health (Scotland) Act 1960.

The minister of health, Enoch Powell, in 1961 announced dramatic reductions in the projected numbers of psychiatric beds which would be required in the 1970s (from 3.4 per 1,000 in 1961 down to 1.8 in the seventies) (Great Britain. Ministry of Health, 1962). But there were no associated plans for developing community services to support the proposed reductions in beds. While the report on community care published in 1963 (Great Britain. Ministry of Health, 1963) listed the plans of 150 local authority health and welfare departments, and noted the important and traditional role that local authorities played in providing community health services, it carefully stated that it was not its intention to provide national plans.

Jones (1972) suggests that there were a number of competing models of treatment for mental illnes current during the 1960s and, by implication, suggests that this was a contributory factor in the lack of clear goals guiding the service during this period. From the progressive developments of the 1950s, there seemed to be a decline in standards of provision and a confusion of aims by the end of the next decade. She lists five different competing models of care: the WHO model which saw a flexible range of options, including in-patient treatment, day care, domiciliary care, together with medical and social work input; the medical model which saw treatment as principally a medical concern and psychiatry as

primarily a clinical discipline (and social work as very much an ancillary service); the Seebohm model which viewed mental illness and mental handicap as social problems, where the profession of social work would be dominant; the 'conspirational' model which interpreted mental illness as part of a scape-goating process whereby sufferers are defined and labelled by society as mentally ill or mentally handicapped and therefore segregated and victimised; and finally what Jones calls the 'no model' theory, which people like Laing propounded, in which the commonly viewed abnormal behaviour of the mentally ill person was, in reality, the behaviour of a normal person reacting to abnormal pressure applied by those close to him/her (usually within the family).

She suggests that forms or models of care reflect values current in society and that the conflict over appropriate forms of care which characterised the period was just such a reflection - namely a reflection of the conflict between central control and local autonomy, authority and protest, and professional teamwork and professional conflict.

This lack of clarity over goals and forms of care persisted into the 1970s. It was not until 1975 that a comprehensive White Paper on the future of mental illness services was published (DHSS, 1975), four years after an equivalent document for mental handicap services (DHSS, 1971a). It reiterated the view that in-patient numbers should continue to decline and that care should be available in the community but was careful not to make precise projections about in-

patient numbers. It recognised that there had been a shortfall in local authority provision which prevented implementation of adequate community care policies.

It noted an unfortunate lack of interest on the part of the psychiatric profession in the care of chronic conditions, which had resulted from the growing demands and interest in acute psychiatry; it also noted that a lengthy debate about the restructuring of thesocial services had exacerbated problems in developing appropriate community services. It pointed out the dangers involved in aiming to do away with the all-purpose mental hospital in favour of placing psychiatric units in general hospitals (an aim proposed in the early 1960s but not put into effect). It warned that such a policy might lead to too high a degree of selectivity in terms of acceptable patient type. The all-purpose mental hospital, it argued, had the advantage of being able to offer a wide range of services to all types of patient. In addition, there were likely to be problems in securing the requisite amount of resources from local authorities in order to develop the necessary community services.

A co-ordinated strategy was essential, involving the development of local authority services, co-operation between different professional staff in different types of setting, improvement in planning and administration and an improvement in staff ratios. It also emphasised the fact that those working in the health and social services had a responsibility to the community at large not to discharge patients into the community who could not be adequately

supported - otherwise 'the whole concept of community care is placed at risk'. It also recognised the heavy strain placed on families having to cope with mental illness.

In addition to reviewing current services and commenting on long-term aims, the White Paper also provided a thorough summary of the nature of mental illness and its classification, the needs of the mentally ill, historical developments in their care and an outline of what was required in the new pattern of services - in relation to teamwork, security, housing and employment, children and adolescents, alcohol and drug dependency and manpower requirements.

The earlier White Paper on mental handicap published in 1971 (*op.cit.*) had covered similar ground; it defined its subject and scope, and reviewed current services and future plans. It confirmed the long-term aims as outlined in the report of the 1957 Royal Commission and the Mental Health Act 1959. In addition, it listed fifteen general principles upon which, it suggested, current thinking on mental handicap was based. This recognised that the mentally handicapped person should 'live with his own family as long as this does not impose an undue burden on them or him' and if this were not possible a 'homelike' house should be provided 'even if it is also a hospital'. It recognised the need for integrated services provided by both the health and personal social services and for close collaboration between all those involved. Mental handicap hospital services, it emphasised, should be close to the populations they served and associated with other hospitals. Social training,

stimulation and education were all essential. A parallel report (SHHD/SED, 1972) was published by the Scottish Home and Health Department relating to Scottish services for the mentally handicapped in the following year.

Seven years later, the Peters report (SHHD, 1979) in Scotland and the Jay report for Scotland, England and Wales (Great Britain. Parliament, 1979) were published reviewing progress in the mental handicap field since the earlier reports. The Jay report was set up in response to the need to consider one of the recommendations of the Briggs committee (Great Britain. Parliament, 1972) which suggested that a new caring profession should emerge with responsibility for the mentally handicapped. This had caused a great deal of controversy within the related professions and the Jay committee was established to consider this array of different views. The report of the committee is characterised by the 'unashamedly idealistic' (para 95) model of care which it proposed. It went on to recommend a single form of training for both health and social services staff in the care of the mentally handicapped and a unified career structure. It emphasised the urgent necessity to implement community care policies and urged the government to make more resources available for mental handicap services which 'would require only a tiny shift in priorities for public spending' (para 386).

During the same period, concern for the elderly was also developing. Documents relating specifically to the elderly were published during

the course of the 1970s looking at a range of concerns. The discussion document *A Happier Old Age* (DHSS, 1978) came out in 1978 as a preliminary to a White Paper planned for 1979, but which did not come out in fact until 1981. The 1978 document is prefaced by a statement of aims which emphasise the need to ensure that retirement does not mean poverty (a new pension scheme was being mooted), that old people should keep active and independent in their own homes and that old people should be able to make decisions about their own lives. Much of the paper is concerned with income and the cost of living; other chapters relate to 'the elderly in society' (that is, preparation for retirement, leisure and employment opportunities, family and community support, keeping fit, death and bereavement), to accomodation for the elderly and to services for those living in the community (that is, health and personal social services, transport and mobility) and to hospital care. It finishes with a chapter on 'the joint approach' - the need for co-ordination and collaboration and ends with a summary of the main issues for debate. It is a comprehensive review of the issues relating to old people and is not restricted to either social service of to health service matters unlike most of the documents relating to mental illness and mental handicap.

This discussion document was followed by the White Paper, *Growing Older* (DHSS, 1981b), not published until 1981. It is much less detailed and much less concerned with setting out aims and issues for debate. It makes few concrete recommendations beyond stating that solving the problems relating to old age would require the effort of the whole community and that the task of meeting these needs cannot be met

'wholly - or even predominantly - by public authorities or public finance'.

In both the discussion document and the White Paper there is mention made of the needs of elderly people suffering from mental infirmity; the discussion document has four paragraphs on psychiatric provision which asks questions about the numbers involved, the sort of provision which is appropriate and the numbers of staff required, and the White Paper suggests that elderly mentally infirm patients are 'best cared for in relatively small, local hospitals accessible to family and friends and capable of attracting a high degree of local community interest and support' (para 819). While the earlier paper asks questions about numbers and future plans for services, the White Paper does not give any clear specifications, other than stating that considerably more psychiatrists with special training will be needed to achieve a minimum target in England and Wales of one psychiatrist with a special interest in elderly people in each health district.

There are, however, two Scottish documents which look specifically at the problems of the elderly mentally infirm - one published in 1970, *Services for the Elderly with Mental Disorder* (usually known as the Millar Report) (SHHD/Health Services Council, 1970) and another in 1978, *Services for the Elderly with Mental Disability in Scotland* (known as the Timbury Report) (SHHD/SED, 1979). Both reports review very thoroughly the extent of the problem, the current levels of services provided and the projected need of that particular group. Both recommend the establishing of special residential units for the

elderly mentally infirm, although they differ in their judgement as to which agency should be the responsible agency: the Millar report suggesting that it should be the local authority and the Timbury report suggesting the NHS. There seem to be no equivalent documents for England and Wales, although the DHSS, in 1983, announced an experimental pilot scheme of three nursing homes for the elderly mentally infirm in three locations in England which would aim at putting into operation a scheme very similar to those outlined in the two Scottish reports (Dalley, 1983).

Turning to the last of the priority patient groups - the physically handicapped and the 'young chronic sick' - there are very few documents that relate specifically to their needs. The most significant item of policy in relation to them was the Chronically Sick and Disabled Persons Act, 1970 (amended in 1971 to relate to Scotland). This, however, was a piece of legislation introduced and piloted through Parliament by a private member (Alf Morris) and was not the result of a government-sponsored inquiry. It is significant in that for the first time disabled people were given certain rights to community support services and to appropriate residential and hospital care. But these rights were not consolidated by mandatory duties on the part of local authorities to provide the necessary services and this has been regarded as a major deficiency. In general, the young chronic sick have continued to be regarded as an appendage of the geriatric sector although now seen as 'inappropriately placed' under the terms of the Act. A further private member's bill became law in 1986 (the Disabled Persons Act), piloted

by Tom Clarke which sought to rectify some of the deficiencies of the earlier act and to provide disabled people with a guaranteed right to a regular review of their needs.

Other policy documents have been published during the 1980s which relate to the dependency groups and to the development of community care. In 1981 *Care in Action* (DHSS, 1981a) confirmed the Conservative government's support of the 1976 priorities. It also carried an appendix presenting the main points of a departmental discussion document (DHSS, 1981c) on community care which stressed the difficulty in coming to an conclusive agreement as to the meaning of the term community care: it might mean the movement of people out of large scale institutional settings into smaller residential homes - or into their own homes; it might mean the prevention of people coming into any form of residential care and keeping them in their existing 'own homes'; or it could mean domiciliary care provided by professionals, or informal care provided by family, friends or neighbours.

More recently, there have been a number of reports published which were unavailable at the time when field-work was being conducted. For example, a report of the Social Services Select Committee (Great Britain. Parliament. House of Commons, 1985) reviewed progress towards community care and found major deficiencies: progress was slow and not enough resources were being put into establishing satisfactory levels of provision for those being discharged from

large institutions which were being closed down or kept at home. Further, many families who were being expected to provided care at home were finding the burden too great.

Two further reports - from the Audit Commission in 1986 (Audit Commission. 1986) and from Sir Roy Griffiths in 1988 (DHSS , 1988)[a] - looking at the organisational and financial aspects of community care expressed criticism of existing provision and made recommendations for improvement. Much of the criticism related to the inability of the relevant statutory authorities to collaborate effectively in providing an integrated and well-coordinated service. The Griffiths report recommended that social service 'authorities' (taken to mean local authority social service departments) should become the lead authorities for community care, that managers should be appointed locally to take responsibility for arranging integrated packages of care for individuals ('care management') and that the financing of community care plans drawn up by local authorities and district health authorities should be dependent on the approval of a 'minister for community care' at central government level. Resources allocated for community care should be protected so that local authorities woiuld not be able to divert them to other areas of their activity. Griffiths saw the appointment of a minister at national level and the ability of central government to ensure that local plans met required standards and agreed policies as the means to achieving progress.

There has been an implicit recognition in the stream of policy documents that have emerged over the years of the problems of achieving change and of ensuring effective collaboration between agencies and between professionals:

> There should be the closest collaboration among the workers caring for the elderly. Mental health co-ordinating committees would help ensure that this is possible.
> (*Services for the Elderly with Mental Disorder*, 1970, p.51)

> the mentally handicapped and their families need help from professions working in services administered by a variety of authorities and departments. It is important that the resources of the health service, personal social services and education services should be deployed in close and effective collaboration. Only if this is done can the relevant professional skills be most effectively used to provide complete and co-ordinated services.
> (*Better services for the Mentally Handicapped*, 1971, para 124)

> The basic aim of the various structuring bodies and voluntary organisations ....., though organisationally separate, should be to deliver a service which is and is seen to be a co-ordinated one. The achievement of this aim will be possible only if both the location and

the timing of health and local authority developments are co-ordinated by effective joint planning

and

Social work, health and voluntary services must work in sufficiently close liaison to make co-operation effective and this involves adequate mutual understanding between all types of staff working with the elderly with mental disability as well as the availability of collaborative facilities.
(*Services for the Elderly with Mental Disability in Scotland*, 1979, paras 3.8, 3.9)

How might authorities of all kinds be encouraged to extend this kind of collaboration and generally to develop wider perspectives when considering how best to serve the needs of old people?

and

What adjustments might be made in the basic and the in-service training of the various professions involved to enable members to develop an appreciation of the importance of teamwork and co-operation at all levels?
(*A Happier Old Age*, 1978, paras 8.2, 8.3)

The community care services are, above all, complementary. At any one time an elderly person or his family may be receiving a number of services, each related to and dependent on the other. The aim is to provide the care

> best suited to the needs of the individual in the most effective and economical way possible. Collaboration between the services is thus an essential feature. (*Growing Older*, 1981, para. 7.3)

The Royal Commission report was perhaps the only document to give explicit recognition to the problems of inter-professional co-operation and organisational collaboration - as opposed to saying merely that collaboration was good and necessary. It recognised that there were serious difficulties in both fields:

> Uncertainties over role, the drive for professionalism developments in the approach to treating patients, and the difficulty of giving guidance on how health professionals should work together in the treatment of patients may all be observed in the evidence we have received

and

> Despite the considerable efforts made at the time of reorganisation to ensure the close co-operation of health and local authorities, we have heard a great deal of criticism of the existing arrangements. The main complaint has been that responsibility for the individual patient or client is unclear, and that as a result he or she may fall between two parts of what should be an integrated service. (*Royal Commission on the NHS Report*, 1979 paras 12.38, 16.6)

The report went on to consider how these problems might be surmounted, although to a large extent it felt that they might be

extremely difficult to solve. In general, it felt that it would be appropriate for the health departments, in consultation with the national bodies responsible for staff matters, to intervene in inter-professional disputes (para 12.43). In terms of organisational collaboration, the general feeling was that the joint consultative committees that had been set up after reorganisation had not been fully effective - although other had voiced great faith in these.

The report considered a number of solutions to overcome the complaints and criticisms, some of which were radical. One solution was to transfer the NHS functions to local government (suggested in the past but always rejected). A second option was to transfer the personal social services from local authorities to the NHS; another solution was to give responsibility for one particular patient/client group to one particular agency (involving members of the same profession being employed by different agencies). The report concluded that better working relationships could be achieved through improvements in joint training, improved and agreed procedures and better communication - rather than changes in the structure and organisation of responsibility.

The problems of poor collaboration and lack of co-ordination which the Royal Commission identified have persisted; the Audit Commission and the Griffiths Report both commented on them. But in contrast to the Royal Commision, they favoured a reorganisation of responsibility rather than hoping that improvements in joint training and joint planning and consultation would change things.

While they did not opt for a *radical* structural reorganisation, Griffiths in particular advocated one agency taking the lead (which might involve certain groups of professionals transferring agencies) and a much closer monitoring of local activity through central mechanisms. It is perhaps significant from the point of view of the present study that the extent of the difficulties in overcoming inter-professional differences is not given a great deal of recognition.

It is clear that commentators and policy makers at national level have seen the problems of failure to collaborate effectively as a root cause of the failure to implement the priority policies. In addition, there has been a view prevalent that such failure is compounded by the inability of the centre to control the activities of the periphery: thus policies devised by central government have failed to be implemented because they have been subverted by local institutions. It is frequently argued (Haywood and Alaszewski, 1980) that changes in health service and local government structures and the pronouncement of national strategies during the 1970s were expressions of a desire to exert greater control by the centre over local activities; that this failed, it is argued, was due to the fact that the new policies were largely exhortatory and not mandatory (Klein, 1983).

During the 1980s, the concern of how central policy-makers can secure the effective implementation of policy has continued - the

Audit Commission and the Griffiths reports being but two expressions. Part of this concern was expressed in the major organisational changes which occurred in the early part of the decade. A tier of health service structure was abolished (areas in England and districts in Scotland), with a unit structure being established at local level. The first Griffiths report (DHSS, 1983), appearing in 1983, introduced the concept of general management into the health service for the first time, doing away with the old-style consensus management in a bid to achieve more effective decision-making. A Green and then a White Paper on primary care were published in 1986 and 1987 (DHSS, 1986; DHSS, 1987); the government announed a review of the NHS in the spring of 1988.

The central problem of the policy process, then, of how policies once decided upon are then implemented or not (and if so, why; or if not, why not) remains. It is at this point the criteria which Hall *et al* suggest are necessary for the emergence and success of particular policies emerge as salient: legitimacy, feasibility and support. How far is it possible to examine fate of the policies relating to the dependency groups against this set of criteria?

In the sense that the policies got onto the political agenda during the 1970s, and that official and public perceptions of the dependency groups as 'worthy' of special treatment (especially in contrast to less deserving groups), it can be said that the policies were seen to be, in Hall *et al*'s terms, legitimate. But at the same

time, there has been competition with other groups for that legitimacy within the health and personal social services themselves. Acute conditions and high-tech medicine have traditionally been more attractive to the medical and nursing professions; social workers have been reluctant to concentrate their attention on 'under-valued' client groups such as the elderly and mentally and physically disabled people. Even 'the general public' tends to be fickle in its support of the dependency groups in the face of claims for support for acutely ill children, or for the purchase of sophisticated and advanced medical equipment.

Thus legitimacy and support on the part of the sectional interests which are party to the policies - and which play key roles in their implementation - may be insufficient, so bringing their long-term feasibility into question. There may also have been an underlying contradiction in the timing of the introduction of the priority policies which further brings into question its feasibility. If, has been suggested, there are strong opposing interests in competition within the field of health and social care, it is arguable that priority can only realistically be awarded to the dependency groups at a time of general economic expansion - so that other sectors do not have to lose resources in a general reallocation of priorities. In practice, however, it seems that the impetus to introduce a priority policy may actually derive from a context of economic decline and retrenchment - that is, at the most inopportune time for the dependency groups top attract support. Thus, it might be argued, there is an in-built barrier to the success of the policies.

One further factor to note is that policies, once declared, do not necessarily remain constant; underlying assumptions or expectations may change over time. There is certainly some evidence to suggest that this is so in the case of the priority policies. Examination of the policy documents which have emerged during the past two decades show significant changes in concerns and emphasis. The problem referred to in *Care in Action* (*op.cit.*) about the difficulty in finding any common definition of the term 'community care' is indicative of this; this lack of agreement (see above) relates to differences in fundamental views about its substance.

The early documents were predominantly concerned with determining appropriate aims, objectives and style of the services to be provided for each of the groups. The priority documents themselves, issued in 1976, were concerned with the place of the dependency groups within the wider context of the rest of the services. There was little questioning of the fundamental responsibility of the statutory services to provide care, although only if this were appropriate from the point of view of the dependency groups themselves. But with the advent of the Conservative government in 1979, there was a change in the ideological values seen to be underpinning the policies. In contrast to earlier assumptions about the state's central responsibility in the provision of statutory services, *Growing Older*, *Care in Action*, and the Griffiths report on community care clearly stress the duty and responsibility of families and 'informal caring networks' within the community to provide care themselves. The statutory services in this schema are

there to 'fill in the gaps' as Griffiths states, rather than to usurp a responsibility which, it would argue, properly belongs to the individual or his or her family.

This shift in fundamental assumptions has implications. The new position expects much greater contributions in the provision of care from the lay sector; more is expected of the public and less of professionals. Professionals are likely to see this as an erosion of their traditional authority and the public, especially families, may resent the greater demands being made on them. This has further consequences for the level of support given to the policies in the long term.

Such, then, is the policy background to the study reported in this thesis. In discussing the manner in which policies come onto the agenda and the conditions which determine their success or failure, some reference has been made to the role that professionals amongst others might play - in terms of how much they lend their support to the policies both through their attitudes and their actions. The following chapter will take up this theme and look more closely at the role of professionals within organisations and at the concept of 'professional ideology' which, many have argued, patterns their attitudes and determines their actions.

CHAPTER TWO

PROFESSIONALS IN ORGANISATIONS AND THE CONCEPT OF PROFESSIONAL IDEOLOGY

In this chapter I shall consider how concepts derived from organisational theory and from the sociology of the professions can be usefully applied to the study of professionals located within public service organisations such as local authority social services departments and, in particular, the National Health Service. First, I shall look at a range of theoretical perspectives on organisational behaviour - including the rationalist view (in which organisations are seen to be coherent, purposive, logically structured systems), the incrementalist approach (which sees rationalist goals subverted or constrained to the extent that action is limited and contained at the margins) and the phenomenological perspective (which stresses the importance of actors within organisations in determining and implementing policy). Accepting the importance conferred on actors within this latter perspective, I shall go on to consider the manner in which they are perceived to be influential - through their ability to control resources (formally and informally), their freedom to define problems, and the nature of their direct interaction with clients. The sociology of the professions stresses the importance of the role of ideology in patterning actors' views; the concept of ideology, especially as it relates to professionals in organisations, will be considered

in some detail in the last section of the chapter. In this way, a framework will be established in which the findings of the interview study (which is the central focus of this thesis) can be statisfactorily located.

A. ORGANISATIONAL THEORY

Consensus and rationality were the twin constructs upon which NHS organisation was formally based during the post-reorganisation period, 1974-82. Even after 1983, when the introduction of general management replaced management by consensus (which, according to the Griffiths inquiry (DHSS, 1983), was deemed to have been a failure), policy formulation and policy implementation have still been seen to be the product of a process determined rationally.

The post-reorganisation period had been characterised by a perspective which believed that common interests and goals could be achieved if rational approaches were adopted in planning and strategy setting; the post 1983 period is still characterised by an assumption at the official level that, while consensus may be difficult to secure because of the competing interests of the many parties involved, rationality in planning and strategy may, nevertheless, be achieved - through the imposition of the will of a single decision maker at each level (the general manager). But in spite of this official assumption of rationality, such a

view is widely disputed in the literature on organisations and organisational theory.

Theoretical approaches to the study of organisations range from models of strict rationality through those of 'muddling through' incrementalism and pluralistic competition of interests, to the conflict and dominant interest theories of political economy. Hunter (1980), for example, sees debate about organisations as revolving essentially around the rationalist vs. incrementalist models. The rationalist model presents a conception of organisations operating purposively with decisions being made with clarity and agreement about goals and objectives. Hunter characterises three stages in the process of rational decision-making: consideration of all possible alternatives (courses of action); evaluation of the possible consequences of action; selection of the most appopriate in the interests of a desired end.

Glennerster (1983) accepts this characterisation of the rationalist model and links it with an emphasis on the importance of planning in order to facilitate the flow of information 'from the environment' to decision-makers so that they can make appropriate decisions. In addition, *joint* planning has been emphasised in recent years by the rationalists as essential to further the coordination of inter-departmental or inter-agency action. Linked to this, according to Glennerster, has been the development of 'reticulist theory' which stresses the importance

of the 'networking' function - the linking of key individuals in different departments or agencies - in facilitating information flow.

The rationalist model (see, for example, Butler (1986) on 'Taylorism') has been criticised by many analysts over many years (but, as Hunter notes, it is an approach frequently adopted by management advisers and consultants in their dealings with public service organisations). Opponents of the rationalist view readily acknowledge that the *formal* model of the NHS is clearly based on rationality - the Salmon report on nursing (Great Britain. Ministry of Health, 1966) represents a clear example of the model as applied to the NHS - and as such is a factor that can usefully be taken into account in interpreting and explaining the competing accounts of actors in the operation of the system. But as an explanation of the *system*, of the *organisation*, it is, they argue, inadequate. They point to the cluster of influences and constraints which operate to impede the functioning of the organisation in rational fashion. Aims and objectives may be identified but progress towards them may be subverted by action (both explicit and covert) and non-action.

This is the 'muddling through' of incrementalist theory (Braybrooke & Lindblom, 1963); the scope for action is limited by the weight of what has gone before, change can be brought about only at the margins. Actors within the larger system have only

limited perception of their circumstances and their potential for decision-making. They do not have a complete picture of the range of possible decisions or potential consequences - they act in a sense of 'puzzlement'. Decision-makers in this context do not or cannot make rational, optimal choices; they tend, in Simon's terminology, to 'satisfice' - do what is necessary in relation to immediate requirements (March and Simon, 1958).

Equally important as the decisions which are made (whether or not they are made rationally or under a variety of pressures and constraints) are the non-decisions (Bachrach and Baratz, 1963; Lukes, 1974). The ability to keep significant issues off the agenda of decision-making has been recognised as an important component of the organisational process. It allows for the continuation and perpetuation of the status quo. What has gone before is thus able to determine the future. The consequence of 'satisficing' and non-decision-taking is that change is slow in taking place; turbulence may be much in evidence but real movement may be lacking. It is the opposite of the entrepreneurial risk-taking, the 'bias for action', advocated in contemporary management literature (Peters and Waterman, 1982).

Certain writers, however, have argued that the incrementalist view is too static. In reality, even though the margins for manoeuvre may be limited, decisions are made and different organisations will demonstrate different capacities in making decisions. Greenwood et al (1977), for example, as cited by

Hunter, ask why some budgetary processes are more or less incremental than other budgetary processes. They suggest that there is scope for action even within constrained circumstances. Hunter himself has demonstrated the scope for action within the health service setting.

Both incrementalism and its (partial) critique link with pluralist theories to the extent that all recognise the power exerted by the competition of those interests which are party to decision-making, and the constraints that these impose on actors in their efforts to make rational decisions. If incrementalists do what is possible, where it is possible, then much of their activity takes place within the margins defined as feasible by the existence of competition around them. This is the picture drawn by Hunter (*op.cit.*) and Brown (1986); the scope for action is limited, much of it is dominated by routine activity. But where action is possible, it has to be negotiated by key actors and the key interests which they represent. Brown, indeed, sees the need for constant negotiation as the key characteristic of organisational behaviour; he sees the main force determining actors' behaviour as that of 'pragmatism' (Brown, 1987).

It is the significance of these key actors and interests which lead both Hunter and Brown, for example, to stress the 'phenomenological perspective' (Carrier and Kendall, 1973; Edwards, 1981) in its own right, rather than adopting the

theoretical positions of one school of thought or another (be it rationalist, pluralist, incrementalist). Thus for them, it is important to look for meaning in the explanations of actors themselves. The essence of the phenomenological perspective is that it is both an attempt to identify the values and beliefs of actors *and*to regard organisations as social systems, rather than to see them as determinate systems governed by rationality and consensus - or conflict and competing interests (according to whichever theoretical position adopted).

There are thus a number of theoretical perspectives which can be brought to bear on the explanation of organisational systems and behaviour. Hunter quotes Klein (1974) as saying that theories as 'tools of explanation .....explain *something*; none explains everything.' That comment is apposite in the context of the health service. It may be that one theoretical approach is insufficient as a complete explanation, but it may be useful in part. Indeed, Hunter advocates a dual perspective - a 'conceptual lens' based on multiple notions of rationality (subjective, objective), along with a conceptual lens based on interpretations of incrementalism.

Although many analysts no longer accept the rationalist interpretation *in toto*, there is no doubt that *formally* NHS organisation is structured on the premises of rationalist theory. Moreover, some of the actors involved may behave *as if* the rationalist explanation were correct. Thus some administrators

for example may support their own interests in decision-making by claiming validity from the formal (rationalist) model. At the same time, however, they claim justification from other perspectives as they point out how they feel their hands are tied and to their inability to effect major change because of the weight of what has gone before and the narrow margins for manoeuvre. The recognition of the empirical existence of the diversity and contradictions apparent in actors' views lends weight to the phenomenological perspective - at the same time it underlines the importance of maintaining a critical distance from the accounts themselves. Thus the accounts themselves can be seen as evidence of the existence of competition of interests at play within the system and to the strength on one set of interests over another - within the health service this has traditionally meant those of medical clinicians over those of nurses, administrators, paramedicals and the like. Perspectives which stress the multipicity and competition of interests are, then, of central importance.

It seems that a variety of theoretical perspectives might be appropriate according to the scale and starting point of analysis. At the wider level, conflict theory - most refined in Marxist analysis - which sees action as the outcome of conflict between dominant forces within society at large and lesser forces, subsumes the pluralistic perspective, which itself recognises the strength of competing (but constantly changing - and therefore, non-cumulative) interests but does not link this

to the structural dominance of one interest over another (see Chapter One). Pluralist theory itself can accomodate the incrementalist view - especially when it focuses down onto the actions of particular actors and the manner in which they are constrained and conditioned by their particular environments. And actors themselves may adopt a variety of interpretations to explain their activities and circumstances.

But explanation in terms of the actors' (differing) interpretations will leave the sociologist perplexed without critical distance being maintained and some wider analysis being brought to bear. In the case of this present study, the explanations and accounts of actors are certainly of central significance - they are, after all, the substance of the study. But a 'second level' conceptual framework is also required against which the varying and often conflicting perspectives of individuals and professional groupings can be set. Glennerster's (*op.cit.*) 'bureaucratic and professional politics model' provides just such a useful framework. He argues that this model can demonstrate how professionals can subvert rationalist intentions in the implementation of policy. Professionals do not constitute 'mere interest groups' as the 'classical pluralist tradition' would portray them. There are elites between and amongst them. There is a hierarchy of status and power not only between but within professions. Members of those elites are able to bring influence to bear on what happens in the policy process.

Disproportionate allocations of resources will come the way of certain groups within agencies and within professions. For any study which is concerned with the part played by professionals in policy-formulation and implementation - such as this - such a model is clearly of importance. It discriminates not only between professions but within professions; it regards professionals (in the broadest definition of the term - see below) as significant in the playing out of the policy process. There is a structural as well as a phenomenological aspect to their significance.

B. SOCIOLOGICAL APPROACHES TO THE STUDY OF PROFESSIONALS

Professionals, as we have seen, are said to be central to any study of the way in which organisations work. But professionals as a category have been the subject of sociological debate; sociologists have long been concerned with deciding on how the term 'professional' should be defined - that is, they have mostly been concerned with what makes a profession different from the more general category 'occupation'. Two approaches can broadly be identified (Larkin, 1983): one which is descriptive and is concerned with trying to identify ideal-type characteristics which denote 'a profession' against which a particular occupation can be measured (the trait or check-list approach) and second, one which is concerned with the process of how and why an occupation seeks to move towards professional

status (usually to do with reasons of power and monopoly control).

These two approaches both represent the sociologist's perspective (Freidson, 1970; Johnson, 1972; Larson; 1979). There is, however, what Freidson (1983) calls the folk concept of profession, meaning how the category 'profession' is used in everyday life by 'ordinary' people (amongst them the professionals themselves). Some sociologists have taaken this as their starting point for analysis and have seen their task as being about documenting how people 'accomplish' being professionals (Dingwall, 1977). Dingwall argues that sociologists should be concerned with 'the empirical investigations of members' commonsense knowledge of social structures...treating it [the concept of 'profession'] as a members' concept and seeking to describe its practical usage.' He warns against treating lay theories as 'impoverished sociological theorising.'

Freidson (1983) counters this view, however, by arguing that it is only possible to avoid the issue of definition by adopting a 'patently anti-analytical position'. He goes on to resolve the problem to his own satisfaction by suggesting a move beyond the folk concept *and* beyond the search for a theory of professions that might be generally applicable, towards the task of developing 'a more general and abstract theory of occupations by

which one can analyse historic professions as well as other occupations in the same conceptual terms.'

But in spite of this broadening of the debate, Freidson has been accused of over-emphasising the pre-eminence of certain of the professions at the expense of over-looking the significance of other occupations (or paraprofessions in Freidson's terms or in Etzioni's (1969), the semi-professions). Larkin (*op.cit.*), for example, suggests that 'Freidson's account of professional dominance, with its primary focus upon doctors, can all too easily render para-medical stratagems unimportant'.

Larkin prefers to concentrate on the issue of professional dominance as being one of the strategies which particular occupational groups within the division of labour choose to adopt in their pursuit of occupational control. Sociological interest, for him, lies in this intense competition between occupational groups for control and dominance. In this way, he says, 'all groups are seen as engaging in occupational imperialism, with greater or lesser degrees of power, authority and success'. This matches Larson's (1979) concerns; he argues that the process of professionalisation is related to the attempts of particular occupational groups to gain privilege within the wider structure of inequality which characterises capitalist society. The strategies by which that privilege is achieved and maintained are to do with control of occupational access and protection of occupational territory - but they are also linked to the

development of an ideology of professionalism which is closely identified with the dominant ideology which underpins wider society.

McKinlay (1977) echoes this view; in discussing Freidson's emphasis on professional dominance (of the medical profession in particular), McKinlay applauds his contribution to the sociology of the professions but criticises him for leaving questions unanswered about the position of the professions in the general class relations of capitalist society (although Freidson does acknowledge the importance of the issue). Issues of power and privilege should be, according to McKinlay, of central concern.

Another theme in the debate about professions has been the theorizing about the relationship between professions and bureaucracy - especially in relation to notions of the challenge by bureaucratic control to professional power and autonomy (medical, in particular) within public organisations. Although some have argued that a number of developments in relation to the rise in status and independence of non-medical professional groups represents a concerted, government-inspired challenge to 'medical hegemony' (Armstrong, 1976), others argue that medical dominance is still the major feature of health care organisation. Stacey (1988), paraphrasing Larkin (*op.cit.*), says 'boundaries may be redrawn without equalizing all the parties'. The status and structural position of other professions may have been altered, but medical power remains.

A number of writers, have concentrated on examining these relationships - both inter-professional and professional-bureaucratic - in a more fluid and dynamic perspective. They see them as being part of the 'negotiated order' (Strauss, *et al*, 1964); interaction and bargaining between all interested parties within the arena of the health care setting are the key elements in this approach (Green, 1974; Abel, 1975). Thompson (1987), for example, sees organisational life within the NHS as being characterised by a series of sometimes shifting coalitions between various interests and various sets of beliefs, most commonly 'practitioner interests' and the 'administrative ethic' - but practitioners will somtimes exhibit elements of the administrative ethic and administrators may align themselves with practitioner interests. He sees these clusterings of influence as particularly important within the NHS since the advent of general management - in terms of the degree to which the new general managers may or may not become centres of new sorts of coalitions of interest. An 'action frame of reference', which Thompson advocates, and which takes account of the beliefs and activities of individuals within the system is, he argues, a more satisfactory approach than a social systems interpretation which sees organisational behaviour as' the outcome of conflict between impersonal systems: professionalism and bureaucracy'.

Alford (1975) makes similar points in his study of health care politics but perhaps lays greater emphasis on the structural context in which the competition and bargaining between interest

groups takes place. He distinguishes three sets of structural interests: dominant, challenging and repressed interests. The first are those which are underwritten by the ascendant political, economic and social institutions of the period; the second are those which contest them and come into play as a result of changing forces in society; the last are those which are repressed by the dominant interests of the day and may not necessarily be articulated at all. But competition and conflict are not confined to the interfaces between each of these major groupings; they may take place within them or between segments of all of them. However, Alford is particularly concerned with the conflict between 'professional monopolizers' who are part of the dominant structural interests and 'corporate rationalizers' (predominantly the administrative and managerial interests within the health care system) who are seeking to challenge the power and monopoly of the former. This approach, too, it might be argued, is relevant in examining the future impact of general management in the health service.

Despite the wider range of views about definitions and differing perceptions of what the significant issues are, it is possible to extract a number of key factors which are of relevance to the current study. The trait approach, for example, itemises as significant (amongst other things) control of access to the profession and the autonomy of professional work, along with the specialised, 'expert', knowledge which underpins professional work. These factors are relevant in the present study both for

their analytical value and in terms of what the professionals participating in the study themselves think about the nature of their work. Likewise, the struggle for dominance and 'control of rival procedures' (Larkin) which are central to the process and activity of professionalism are both of particular interest in any study which is concerned with the allocation of priority and prestige in conditions of scarcity. Insights derived from studying the bargaining processes and the formation of coalitions within organisations are of equal importance; further, the complex relationships betwen professionals and administrators or managers remain significant. And in the sense that the underlying concern of the study is about fundamental relationships of equality and inequality in relation to particular dependency groups and the professional groups charged with their care, the arguments with which Larson and McKinlay are concerned about the place of the professions in class relationships in capitalist society become salient.

C. PROFESSIONAL INFLUENCE

In more concrete terms, however, it is possible to detail how professional groups affect the manner in which policy might be formulated, the content of that policy and the way in which it is implemented. Professionals, usually under the leadership of their professional associations, may either formally champion or resist certain policies at the stage of formulation. Government appointed committees of enquiry, royal commissions, working

parties may recruit professional representatives to their membership or take oral and written evidence from relevant professionals and their associations. The negotiations between Aneurin Bevan and the medical profession at the inception of the National Health Service are frequently cited as an example of professional power dominating governmental power (Stacey, 1988). Likewise, the reorganisation of both the health and social services in the early 70s has been regarded as the reorganisation of services around professional skills (in the interests of the professions) rather than around patient care (Haywood and Alaszewski, 1980). In addition, policies may be reformulated not because of formal representations of advocacy or resistance, but because of *expectation* of one or the other.

Dunleavy (1981) suggests that the professions have considerable power in their ability to influence the climate of policy-making. He suggests that this is achieved by the cumulative effect of individual professionals thinking creatively about their field, about advancing knowledge and promoting change and innovation. This may be followed by intense debate with rival solutions being championed. This process - what Dunleavy refers to as 'ideological corporatism' - tends to polarise professions around rival solutions and to foster the tendency towards shifts in policy 'fashions'.

Policy may be subverted or modified in other ways: failures in collaboration between different professional groups and agencies

may lead to breakdown in policy implementation. Recent inquiries into child abuse cases, for example the Butler-Sloss inquiry (DHSS, 1988b), have laid the blame for the failure of agencies to cope satisfactorily, partially, at any rate, at the feet of competing professional interests.

Another factor may be the development and growth of 'new' professions which may have repercussions on the playing out of the policy process. Tension, ambiguity and conflict are frequently the concomitants of change; an extension of the territory and expertise of the newer professions may encroach on that of the older professions. Inter-professional rivalry is likely to provoke strain and competition which in turn will impede the smooth implementation of policy (Alford, 1975).

In discussing the relationship between professionals and power, Wilding (1982) describes four areas in which professional influence operates. Defining policy-making, by implication, as those macro-level decisions flowing from the top downwards, he, too, suggests that professionals play a key role at the formulation stage. But there are three other areas where their influence is significant: in their ability to define needs and problems, in their participation in the process of resource allocation, and in their ability to wield control over their patients or clients.

Wilding cites the example of the medical profession in relation to the ability to define needs and problems. He argues that it has successfully ensured that society (and government) has defined health in terms of medical treatment and health services; dietary and environmental influences, for example, have only recently become to be seen as significant. In relation to the allocation of resources, the medical profession, again, has great power through the exercise of 'clinical freedom' to demand and gain access to resources as it deems appropriate. Indeed, clinical freedom is one of the major defining characteristics of the profession of medicine - and it is a freedom which other professional groups claim as they seek professional status. Further, professionals, through their exercise of relative autonomy, have substantial power in the allocation of a central resource - their working time - as they see fit; they are able to choose with which clients they spend the most, or the least, time (and thus ration that resource). The power which professionals are able to exert over people as individuals is thus extensive; they may define the problems and design the services to solve them; they may determine what attention individuals receive; and they are in powerful positions to make choices 'on behalf' of individuals who are never allowed the opportunity to say whether they want them to or not.

A number of writers have stressed the importance of the role of professionals, as practitioners, in moulding the outcome of policy - through their ability to influence the allocation of

resources, the design of services and what treatment members of the public receive. Lipsky (1980), for example, is concerned with the extensive power of front-line workers to determine the policy of their organisations in relation to their clients. He decribes how 'street-level bureaucrats' (front-line workers), operating in the 'corrupted world of service' have to reconcile a general and diffuse obligation to the 'public interest' with the need to make immediate and difficult decisions about individuals which may well affect their life chances. Such decisions are likely to be both redistributive as well as allocative - thus individual members of the public are dependent on the discretion of these street-level bureaucrats to determine who receives cash payments and services at the expense of others who do not. Lipsky suggests that where the scope for decision-making by individual practitioners is wide, the sum of such individual action adds up to *agency* behaviour and, further, this may contrast markedly with the attitudes of agency members based at higher levels of the organisation (and, by implication, *formal* agency policy).

In his study of resource allocation in a social services department, Judge (1978) sees the process of rationing as falling into three separate categories: financial, service and consumer rationing. He refers to the arbitrary means whereby clients may be implicitly dissuaded from applying for certain services - by such things as the introduction of elgibility clauses, relying on consumer ignorance, the stigma attached to receipt of certain services, procedural complexity and poor physical access.

Professionals may play a part in a number of these processes and in choices they make about how much time they spend on individual clients in the casework relationship.

Adler and Asquith (1981), too, are concerned with the role of discretion in the distribution of welfare; they discuss the relative advantages of welfare systems based on the one hand on rules and on the other on discretion - centring on the tension between rigidity and flexibility while at the same time aiming to ensure equitable treatment in determining what is appropriate for the numerous variations in individual situations. They note that systems based on discretion are attractive to decision-makers who are professionals of high status and power - the ability to make such discretionary decisions reinforces that status and power and enhances the importance of their positions.

In her description of the activities of probation officers, Hardiker (1977) points to the way in which the 'exigencies of practice' mediate between ideal ways of practising the profession and the reality constrained as it is by factors such as lack of resources and the decisions of other power-holders in the system; Rees (1978) discusses similar effects in the practice of social work. The discretion exercised by general practitioners has been noted by several writers (Cantley & Hunter, 1985; Dalley & Thompson, 1985). Their key role as gatekeepers to a number of other services allows them to make choices on behalf of their patients without the criteria for those choices being

systematised or explicit; but they are also subject to pressures and constraints (such as resource shortages, difficulty of access, their own limited knowledge of services) which are not immediately obvious. They thus become engaged in a rationing system which is not explicit and which may inhibit equitable access to services. Smith (1986) sees the impact which front-line workers have on policy and service delivery as one of four key issues facing health and welfare services research during the coming decade.

Evidence and assertions such as these point to the importance of the activities of front-line workers - professional practitioners - in determining and defining the work of their employing agency. Contrasts are drawn between policy which is seen as being determined 'at the top' and imposed upon the structure below and policy which is seen to be determined 'at the bottom' by its practitioners and thus characterises the operations of the agency as a whole.

The 'top-down' view of policy-making is a feature of rationalist theory but it seems that there is sufficient evidence to suggest that the model of organisations derived from rationalist theory - which sees policy-making as an effort to achieve outcomes based on the equitable satisfying of all parties with an interest in the process - does not fit well with the picture drawn above of professional concerns and self-interest, of competition and constraints. In rationalist theory, the more technical and

therefore 'objective' criteria that can be established by which to form judgements (both immediate and long-term), the more rational the decisions will be and the more efficient and appropriate the outcomes. But in practice, the intervening factor of professional influence is a powerful one. Rationalist theory might accomodate the capacity of professional groups to modify 'rational' policies (either through formally recognised influence, or through the unintended consequences of action, or through inter-professional competition), by seeing it as a distortion. Alternatively, it can be seen as providing evidence to refute the theory of rationality. It is this alternative view which this study adopts as its theoretical framework. Nevertheless, for those subscribing to the rationalist view and responsible at the macro-level for laying down the broad guidelines of policy, the intervening factor of professional influence must be seen as an aggravating distortion.

D. PROFESSIONAL IDEOLOGY

The concept of professional ideology was introduced by writers such as Mills (1944), Sharaf and Levinson (1957), Hollingshead and Redlich (1958), and Strauss *et al* (*op.cit.*) to explain the differences in attitudes and approaches which members of different professional groups exhibited within the context of the workplace (especially, in much this evidence, in psychiatric settings). Moreover, it was suggested that professional ideology

was the vehicle for differences in models of practice and as such determined modes of treatment for the patients and clients concerned. Identified in this way, professional ideology is clearly perceived as a determining factor in the transmission of professional influence as described in preceding sections of this chapter and should thus be examined in more detail.

A number of professional ideologies have been described in the literature. Huntington (1981) contrasts social work ideology with medical ideology: the former, she suggests, is characterised by an aim to enhance the social functioning of individuals and groups within their environments; it has a psycho-social and preventive orientation, focusing on the restoration of normality and acceptable quality of life. The latter, on the other hand, is characterised by a bio-physical, curative orientation; it is concerned with individual pathology and its clinical cure. It is action-focused and less concerned with the social settings of its subjects. With a rather different emphasis, Armstrong (1983) describes how medicine has been characterised by a series of discourses which reflect the changing focus of the medical 'gaze' and which centre on the changing conception of the body in medicine. Nursing ideology has also been the subject of study: Williams (1978) points to two themes which have dominated - those of 'Profession' and 'Vocation' - both of which are significant in the definition of nursing tasks in relation to the sick and helpless adult and the first of which is important in relation to

nursing's claim to 'autonomous nursing control over the direction of a sick person's care.' She also draws attention to the relationship between nursing ideology and models of male dominance and female subservience.

Professional ideology, of course, is a concept which needs some definition. Its antecedents lie, perhaps, with political philosophy which, since the late eighteenth century, has been concerned with defining the term 'ideology': it has been seen as an all-embracing doctrine or set of ideas and values which encompasses the relationship of man and woman in society, from which derives a programme for action; further, it has been seen as operating to support and validate the interests of certain sectional groupings or classes over others, while at the same time persuading those others that this is valid. In Scruton's (1982) words, ideology (following Marxist definitions) 'has three principal functions: to legitimate, to mystify, and to console.'

Apter (1964) stresses the link between action and fundamental belief and the essentially moral basis of action which that implies as the central characteristic of ideology. He sees it as having two functions, one at the collective level of binding the collectivity in solidarity; and one at the the individual level, of 'organizing the role personalities of the maturing individual'. As a consequence, he argues, ideology plays a crucial role in legitimising authority.

In his discussion of ideology, Geertz (1964) is concerned with the problem which Mannheim (1960) identified of overcoming the difficulty of studying and analysing ideology when, as he argued, all forms of thinking were conditioned by the intellectual and value-laden environment which produced them (Manning, 1985). Geertz feels the problem can be resolved: that the scientific enterprise, though related to ideological thinking, can be separated from it and utilised in the analysis of ideology. For him,

> ideologies do make empirical claims about the condition and direction of society, which it is the business of science .... to assess. The social function of science *vis a vis* ideologies is first to understand them..... and second to criticize them.

Geertz accepts the definition of ideology that Fallers (1961) employs: ideology is 'that part of culture which is actively concerned with the establishment and defence of patterns of belief and value.' This is a usefully broad definition because, although it does not discuss 'establishment *how*' and 'in whose interests', it does emphasise that ideology is something which is contestable. Thus *dominant* ideology is 'that which successfully establishes and defends its hegemony - overriding others' interests and buttressing those which it underpins' (Dalley, 1988a). It recognises that ideology(ies) operate(s) in a competitive arena - although perhaps heavily weighted in the direction of one interest or another.

Ideology, then, is both a way of viewing the world and a mechanism for imbuing the thought and attitudes of men and women *in* the world with moral implications for action. Applied to the context of professional action, definitions have, of course, to be more limited. If

> ideology can be defined as a patterning of beliefs and values relating to views about the ordering of the world at relatively high levels of abstraction [then] *professional* ideology is that part of wider ideology which underpins world views insofar as they relate to professional practice (Dalley, 1988b)

It has been pointed out that writers in the 1950s and 1960s were somewhat imprecise in their usage of terms. Marx (1969) notes that various terms have been used interchangeably: 'position', 'orientation', 'philosophy' and 'ideology'. However, Marx sees a common view underlying this mixed usage: the writers concerned see phenomena that can be called 'professional ideologies' as 'shared belief systems which guide and justify purposeful therapeutic actions.' Strauss *et al* (1964) saw ideologies as being associated with institutional locales, as affecting the organisation of treatment and as being strongly conditioned by professional affiliation. Marx (1969) saw professional ideologies as consisting of a number of component orientations which when organised into coherent belief systems offer a basis for behaviour which 'cannot be predicted solely on the basis of the separate components that contribute to them.' And,

significantly, 'the most important emergent property of ideologies is a morally charged mandate for action.'

Studies undertaken in the 1960s laid the foundations for the later development of thinking about the concept of professional ideology. During the following decade, acknowledgement of the work of Strauss and colleagues, Geertz, Marx and others was recorded in many contributions on the subject. Two problem areas began to emerge: one, in terms of explanatory theoretical frameworks and the other, in relation to identifying the existence of *multiple* ideologies within the larger category of professional ideologies. Both issue areas already figured in the earlier work: Geertz (1964) discussed the ways in which the notion of ideology had been accounted for in the theoretical literature and Strauss et al (1964) described the conditions under which different ideologies seemed to emerge but this was developed further by writers such as Mauksch (1973), Voysey (1975), Smith (1973), Hardiker (1978), Goldie (1977) and others during the 1970s.

Theoretical frameworks

Geertz suggests that there are two main explanatory frameworks available in the study of ideologies. One is *interest* theory which sees ideology as a consequence of, and vehicle for, the competition of self-interested forces in society at large. The motivations underlying self-interest are rooted firmly in the

socio-political structural positions in which those self-interested individuals or groups are located (although Geertz points to the lack of analysis of the nature of that motivation). The other is *strain* theory which sees ideology as the expression of social disequilibrium and the outlet from it. Men and women seek to come to an accomodation of that disequilibrium; ideology provides the possibility by a number of means: through scapegoating, through building morale, by building the solidarity of the group or by making public the causes of grievance. Geertz says that in interest theory, 'ideology is a mask and a weapon; for the second [strain theory], a symptom and a remedy.....In one, men pursue power; in the other, they flee anxiety.'

Taking Geertz's work as a starting point, Smith (1977) finds interest theory persuasive up to a point but goes on to find greater utility in the insights gained from strain theory. At the outset of his study of the ideologies of those involved in the children's panel system in Scotland, he states that he decided to use Strauss's 'unproblematic' definition of professional ideologies (as a *working* definition) - ideology is a 'configuration of relatively abstract ideas and attitudes, used to characterise some perfect state, in which elements are bound together by a relatively high degree of inter-relatedness or functional interdependence': it was free from perjorative connotation and did not carry any implication as to the truth or falsity of its content.

This definition, Smith found, proved insufficient; it could not take into account the varied nature of ideological expression nor the inconsistencies which respondents expressed between their beliefs (ideologies) and their perceptions and experiences of reality. Smith prefers to look at aspects of strain theory as developed by Scott and Lyman (1968). From them, he takes the notion of the 'account'; this he characterises as an operationally specific justification, or rationalisation, of 'actions and situations which do not conform to the actor's ideal and over which he appears to have minimal control.' But he also stresses that it must be grounded in the broader ideological context; in this way the account is 'powerful in resolving strain.'

He distinguishes the account, or in his terminology the 'situated account', from what Strauss calls 'operational philosophies'. Strauss *et al* (*op.cit.*) use the latter term to denote the manner in which highly abstract sets of beliefs are put into practice in the working environment. They are 'systems of ideas and procedures for implementing therapeutic ideologies under specific institutional conditions' - they mediate ideologies and link them with action. As Smith says, they guide action. Situated accounts, on the other hand, according to Smith, make sense of situations which are filled with perplexing contradictions and which would otherwise be incomprehensible or meaningless. He further suggests that the distinction between operational philosophies and situated accounts is a reflection of a similar

distinction that can be drawn between ideology as portrayed in interest theory and ideology as characterised in strain theory.

Multiple ideologies

The second issue area which has been identified in the literature is the presence of multiple ideologies in the locales under study. In one sense, this is not problematic; for Strauss and others, the interplay and competition of different ideologies, generated by differences in professional affiliation, theoretical background, training and institutional setting, is central to the study of professional ideologies. Problems arise, however, when the beliefs and attitudes of groups or of individual subjects are examined in detail and inconsistencies or great variability are demonstrated.

Smith notes that several writers (Wessen, 1958; Gilbert and Levinson, 1957) mention apparent inconsistencies or incoherences although, he argues, they tend to set them aside, putting them 'in parenthesis', rather than trying to take them into account in their explanatory arguments. Instead, Smith suggests, it is important to try to build them into any descriptive analysis; a theoretical model which argues simply that ideologies are systems of coherent, internally consistent sets of beliefs and that professional responses straightforwardly reflect a single ideological position is clearly insufficient. He goes on to argue that ideologies and operational philosophies are *indeed*

consistent and coherent, but that also they are regularly distorted in their implementation, by the experiencing of 'subjective reality' by the individuals professing those ideologies and philosophies - hence the rationalisations of the 'situated account'. These must be just as much a part of the theoretical model as the consistencies of ideological position.

But along with the recognition of the gap between the ideal world of ideology and the everyday 'real' world of practice, the literature on professional ideologies also draws attention to the fact that a number of different ideologies may be at play not only within a single locale (where several professional groups may be in competition) but also within a single profession. Thus Mauksch (1973) discusses first a major ideological cleavage between 'care' and 'cure' which is widely exhibited within the hospital setting; he then goes on to present a six-fold typology of 'task orientations' which form part of the wider patient care ideology. Smith (1973) identifies a number of ideologies exhibited by social workers involved in the children's panel system: these ideologies related to the issue of need and differed along a number of dimensions concerned with views about causes, assessment and location of need. Goldie (1977) draws attention to what he calls 'welfare worker', 'therapist' and 'dissident' ideologies which in some measure are found in all three professional groups under study - social workers, clinical psychologists and psychiatrists. Halmos (1970) has discussed how

one ideological perspective spans a number of different professional groups: the 'counselling' ideology - a feature of the 'personal service' society - is one which advocates 'concern, sympathy and even affection for those who are to be helped by the professional practitioners. It also advocates the continued extension of knowledge and skill, yet it admits the central significance of concern and personal involvement.' Social workers, psychiatrists and psychotherapists all exhibit this approach.

The ideologies of social workers and doctors have been examined by a number of writers in some detail. Giller and Morris (1981) for example contrast the ideologies of casework with individuals and of justice both of which they found in their study of social workers' decisions about delinquents. Hardiker (1977), in her study of social workers in probation work, found similar contrasts. In their study of general practice, Jefferys and Sachs (1983) draw attention to alternative ideologies - the holistic view - relating to the role of medicine which contrast sharply with the usually accepted depiction of medical ideologies based on the 'medical model'.

The picture presented, then, by a variety of writers is of the concept of professional ideology being significant but complex. Professions and the locales (Strauss *et al, op.cit.*) in which they work are characterised by particular ideologies - that is, coherent and consistent sets of beliefs about the world, the

roles of men and women in society - and in the world of professional practice -, which provide a morally charged basis for action. They may be seen as demonstrating and being part of the competition between significant oppositional forces; or they may be seen as the means of expressing and resolving tensions and contradictions within or between groups. Ideologies, it should be stressed, are contestable; there may be competing ideologies within particular locales between professions, *and also* within particular professions. But ideologies are pitched at the abstract level. For them to have meaning and to be relevant in the daily world of action, they must be operationalised - hence the notion of 'operational philosophies' which provide the 'programme' for action. Nevertheless, in practice individuals find the world to be at variance with both the abstract concepts and the operational precepts of ideology; as well as continuing to profess the beliefs which ideology has made evident to them, they also have to make sense of the world as they find it. The 'exigencies of practice' (Hardiker, *op.cit.*) require justifcation; ideologies have to be rationalised.

However complex the issue of professional ideology may be, it is clear that those who have studied the impact of professionals on policy and practice see it as a key factor in the construction of professional influence. Ideology in all its manifestations - and rationalisations - is seen to be the vehicle of professional influence.

E. DISCUSSION

This chapter has been concerned with examining the theoretical framework in which the study of professional views is placed. It was necessary first to look at organisational theory: to review the arguments of various writers relating to explanations of structure and process in organisations. The logical attractions of rationalist theory, while providing a rationale for action for some actors in the organisational setting (namely administrators and managers), offer an unsatisfactory and static model of organisational behaviour as a whole. Equally, the incrementalist interpretation leaves actors little room for manoeuvre in a world dominated by routine and limited strategic flexibility. Conflict theory which sees social relationships and social organisation structured - both overtly and implicitly - on the competition of rival interests bears greater resemblance to the 'real world' of organisational life. Coalitions and conflict are part of everyday reality in public service organisations (Thompson, *op.cit.*). The rival interests which make up those organisations are continually in contest; although there are persuasive arguments which suggest medical interests are particularly powerful, conclusive evidence of their hegemony is lacking (Armstrong, 1976; Strong, 1979). The picture drawn in pluralist theory of shifting coalitions and dynamic regrouping of one set of interests against another seems closer to organisational life. This picture focuses attention on the central significance of the actors involved.

Those actors - in agencies such as the health service and local authority social service departments - are the professional practitioners and their managers. Sociologists have disputed precise definitions of the category 'profession', but the commonsensical lessons to be drawn from their debates seem to suggest that practitioners seek to establish their occupational ascendancy by seeking to acquire and secure the label 'professional' and that this struggle is an integral component of the pluralistic rivalry which characterises organisational behaviour as a whole.

In practical terms, professionals wield influence in a variety of ways. Professional opinion, at national level, develops an 'ideological corporatism' (Dunleavy, *op.cit.*) which will exert powerful control over policy and practice in both central and peripheral agencies. At the local level, at 'street level' (Lipsky, *op.cit.*), professionals are able to influence, and even determine, policy through their ability to control the allocation of resources, the operation of their discretion and their power to define needs and problems.

The manner in which this power is conveyed, it is suggested, is - at least in part - through the medium of professional ideology. Different professional groups are characterised by particular sets of beliefs which provide a framework for action. Professional ideology can be seen as a mechanism for expressing and promoting one sectional interest over another or as a means

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of expressing and resolving strains and contradictions in the contexts of beliefs and practice. But there may be several professional ideologies, even within a single profession, and there may be wide disparities between ideology and practice. While ideology is set at the over-arching, abstract level, 'operational philosophies' (Strauss *et al*, *op.cit.*) provide the mechanism for operationalising them - but the 'exigencies of practice' (Hardiker, *op.cit.*) frequently distort the implementation of those operational philosophies. The notion of the 'situated account' (Smith, 1977) has been employed to describe how the divergence between ideology and practice is accomodated.

This review of organisational theory and the significance of professionals and their ideologies, then, provides the background to the study of professional attitudes which this thesis will now go on to present.

CHAPTER THREE

THE STUDY OF PROFESSIONAL ATTITUDES: AIMS AND METHODS

A. AIMS

Professionals, on the evidence examined so far, are key actors in the policy process. On this basis, the study of professional attitudes was undertaken. It drew a sample from three Scottish locations: Glasgow, Aberdeen and Elgin, regarded as typical of the three sorts of urban settlement in Scotland (large city, medium sized city and small market town).

Three main propositions underlay the initial aims of the study. First, it was posited that professionals would have some definition of client or patient need that was specific to their professional interest - and, as such, different from the 'administrative need' of the service planners, and the 'moral need' of patients and clients and/or public opinion. Second, it was proposed that professionals working in the three different locations where the study took place might have differing sets of attitudes which could be related to the particular circumstances of the setting. At one extreme, it was suggested that the large-scale bureaucratic and densely peopled setting of Glasgow would affect relationships and attitudes differently from the small-scale, personalised and face-to-face setting of Elgin at the other extreme.

Third, it was proposed that differences might emerge not only between professionals' and others' definitions, between one location and another, but also between different groups of professionals. As has been shown, the sociology of the professions has been much concerned with the structuring of professional ideology and the competing claims to dominance of one profession over another. It was reasonable to propose, therefore, that there might be a relationship between the differences in ideology and the competition of interests which professionals exhibited and their attitudes towards a whole set of policy and moral issues.

Information to be elicited during the course of the interviews which were conducted with professionals fell into three broad categories: first, biographical information about the respondent. Second, an account was sought of the respondent's experience of day-to-day working relations within his/her own organisation and within and between professions - especially differences in work practice and orientation and/or professional differences. Third, were questions relating specifically to policy issues - questions about community care as opposed to institutional provision; the relationship between individual, family and state responsibility for the care of dependent people; the role of the voluntary sector; views about the need to reorganise state services and reallocate resources in line with central government policy; ideas about where and how improvements might be made. It was intended to build up a picture of how professionals, going about

their daily business of caring, treating and managing, felt about some of the key issues which underlay their activities.

I wanted to know, for example, what their stances were on the moral issues of responsibility. The policy documents may present the argument for the reallocation of resources in favour of the priority groups in terms of economic equity: they have had fewer resources in the past; it is equitable to redress the balance in their favour - and in terms of social sagacity: invest resources in their care now, in order to prevent the system from being swamped in the future by the volume of increasing numbers. But the issues, in reality, are much more complex than that. Choices about priorities may be influenced as much by perceptions of social worth or need as by considerations of economic equity. And social worth and need may be perceived differently by the different parties involved in decision-making: the politicians, planners and professionals, along with the public at large and the dependent populations themselves.

After all, the issue of dependency raises the question of public and private responsibility. Professionals as actors in this arena are likely to have strong views which may be influential. How far is it the responsibility of the individual to make provision for him or herself in times of dependency; how far is it the responsibility of the family of a dependent individual to bear the responsibility for care; and how far is it the duty of the state to do so? Further, what form of care should be made

available (either publicly or privately)? At home, or in institutions? What part should notions of privacy, independence, collective action, collective responsibility, collective support play in the working out of these issues?

None of these questions is raised in a vacuum. Families already care; state services already exist. But the sort of answers given to the questions outlined above will indicate the general moral climate in which decisions have to be made (by all those involved). Further, they impinge on broader politico-moral views about the nature of the state - especially the *welfare* state - at a time when the ideological lines have been drawn more sharply than ever before (West, 1984).

Professionals operate at the fulcrum of the public/private relationship. They mediate between state (the resource supplier, the planner and provider of services) and public (the informal carer and the patient or client). In one sense, they are agents of the state (they interpret and implement, and thus mould, policies) and in another sense, they act as advocates for the public (making demands of the state on behalf of the public). Their power and influence is thus diffuse and there is wide scope for discretion and variability in the extent to which and the manner in which it is wielded.

In addition to their moral attitudes, I was interested in professionals' views of policy matters. Was there a consensus

about the priority policies and was there any contradiction between professionals' views about social responsibility and their views about specific policies. There is a significant difference between what might be termed a moral position and that which can be called a policy position. Moral views tend to deal with abstract, high-level issues, removed from the concrete realities of daily experience; views about policy - especially, as in this case, it is policy which relates to professionals' own areas of work - are much more grounded in reality. Professionals are in a position to judge - in a subjective sense - how far policies are likely to prove practicable; how far they are likely to 'fit' the moral climate of the times, or their own moral positions; and how far policies serve the interests of the professions themselves. They are also likely to be knowledgeable, either partially or broadly, in an expert sense about the subject matter of policies - in contrast to the public which tends to be characterised by inexpert, highly specific and experiential knowledge or by sweeping unsubstantiated assertion.

I was therefore keen to examine professionals' views about policies. Did they support the avowed move towards community care; did they support the proposition of increased preferential resource allocation in the direction of the dependency groups, and if so, which particular groups should have greater or lesser priority. Were there other ways of improving the services offered - by improving efficiency; by transferring resources

between different sectors of the service; by greater stressing of prevention rather than treatment and so on.

And in discussing policy issues with professionals, I hoped to be able to identify what it was in the *status quo* that professionals found wanting; whether problems which they were concerned about related to policy or organisational structure and what in their view might improve matters. I wanted to find out whether the problems which they identified were more to do with the relationship betwewen actors in the arena or more to do with structural or policy issues than 'process' issues. If the former were the case, I wished to examine the nature of inter-professional relationships. Did differences in outlook exist in relation to moral issues, to policy implementation or to organisational structures and how far did any consistent patterning emerge in those differences. Did they amount to what might be called *ideological* differences.

By building up a picture of professional views about the moral and policy issues, and about the daily working relationships between professionals, it becomes possible to consider the impact that such views might have on the policy process, especially in contrast or as complementary to the impact of public views.

B. METHODS

The sample

The intention of the study was to document the views of as wide a range as possible of actors involved in the statutory organisations responsible for the provision of care to members of the dependency groups. Those actors are referred to as 'professionals' although this ignores the distinction that clearly exists between those located in organisations who work as professionals (i.e. they practice their profession; they have varying degrees of clinical autonomy) and those, who may be qualified as professionals, or may have administrative backgrounds, but at the time of study were working primarily as managers/administrators - it should be remembered that the distinction between manager and administrator was much less clear at that time than is the case since the introduction of general management with its distinctive 'managerial' ethos. I have used the term 'professional' to cover all categories of respondents partly as a form of shorthand but partly to indicate that all respondents were participants in the operational arena of service organisation and delivery - as distinct from those placed at higher levels, where national, long-term planning takes place removed from the operational levels of health board and below. In addition, many of the respondents had professional backgrounds although they had moved into managerial positions during the

course of career development, thus the distinction between professionals and managers, again, is somewhat blurred. Nevertheless, it is a distinction that is shown to have some relevance, as analysis will demonstrate.

Interviews were conducted with 236 health and social work professionals in three locations in Scotland - the south-west district of Glasgow, Aberdeen city and Elgin. The sample was composed, on the health service side, of Area and District Health Board officials, consultants, GPs, hospital nurses (senior nurse managers down through middle management to ward sisters), district nurses, health visitors (and their managers), hospital and community health administrators. On the social work side, it consisted of directors of social work and senior management, down through middle management to 'front line' management (senior social workers and team leaders, officers-in -charge, home help and occupational therapy organisers) and basic grade social workers.

The sample was selected on a random basis from total staff lists wherever possible. Where total numbers were very small, it was more often a case of selecting 50% or sometimes 100% of the total. This was particularly so in the case of the smallest geographical location (Elgin) and at the most senior levels. The directors of social work in both regions were interviewed; likewise all the senior management of both health boards. The interview format was semi-structured and took between one and two

hours to administer. All interviews were tape-recorded and transcribed. The resulting mass of qualitative information was eventually converted into systematised data and coded according to both respondent and issue (236 respondents and 156 variables).

The interview schedule

The broad aims of the research have been outlined in the first section of this chapter but at the outset of the fieldwork it was necessary to convert those aims into tangible research strategies and questions. As a first step a series of basic questions was posed:

1. Should there be a reallocation of responsibilities and resources within and between the health and social work services for the care of
   - mental handicap and mental illness
   - disability and chronic sickness
   - elderly?
2. Should there be a reallocation of responsibility and effort between the formal services and
   - self
   - family
   - voluntary effort?
3. Should there be a reallocation of resources in favour of the Cinderella services?

   If total resources remain constant, from which other sector

- health or social work - should the resources be withdrawn?

4. Between the various dependency groups which now require the highest level of priority? Why?

5. Should there be changes in the nature of services provided for dependency groups?

   a) Should more emphasis be placed upon community as opposed to residential services

   b) Should more emphasis be placed upon preventive as opposed to curative services

   c) Should individuals and families be given more direct support to help themselves rather than the provision of professional services?

6. If respondents answer *yes*

   - what specific changes
   - do they apply to all dependency groups
   - are there any exceptions
   - how would they be beneficial to the dependency groups and to service providers
   - what are the obstacles to change: statutory; structural; ideological?

   If respondents answer *no*

   - does this apply to all groups and services
   - would such a shift have harmful consequences
   - should there be shifts in the opposite direction

- what specifically
- what exceptions
- what benefits?

[Questions taken from research notes]

The next task was to build those questions into an interview schedule which was flexible enough to be administered productively in terms of pitching questions at different levels of complexity to the diverse range of respondents selected as members of the sample. It also had to be comprehensive enough to cover the wide variation in concerns and experience that such a broad range of respondents was likely to display. The interview schedule (see **Appendix I**) concentrated first on biographical information - current post, qualifications, past employment experience, membership of professional associations and so on. Then more detailed questions about current work were asked - tailored to cover the difference professional posts concerned. Inter-professional relationships were then investigated. The interview schedule followed a consistent pattern for each respondent, but there were supplementary probes which could be employed as and if necessary - usually if the respondent was not forthcoming or if he or she tended to dwell too long on unrelated issues.

Ability to influence policy or express views about organisational procedures and activities was another topic for investigation, followed by questions about the sort of constraints respondents

felt they had to operate under. In this way I hoped to build up some sort of picture of the working environment in which particular individuals - themselves the products of particular training and employment experiences - were placed.

The interview then moved on to the questions relating to the priorities policy: first, a question about the definition of the term community care and thoughts about its importance. This led into the politico-moral domain of attitudes about family and state responsibilities in relation to the provision of care for members of the dependency groups. As supplementary to this, questions about the appropriate role for the voluntary sector followed, along with an exploration of respondents' attitudes to levels of public expectations of the services and whether they felt the public expected too much of the services - and whether they felt people were prepared to care for their dependent relatives.

Following questions which related essentially to the moral questions about caring, I then asked for their views on the specific policy issues: did they agree with the priority policies and, if so, which sectors should lose resources to allow for reallocation in favour of the dependency groups? Should any particular dependency group have greater priority than any other? Further, if no extra resources were to be forthcoming, could there be other ways of reallocating existing resources (by transferring between agencies, through the amalgamation of

agencies, by making savings through rationalisation of services, by better 'housekeeping', cutting down on administration and so on).

I then wanted to investigate what sort of alternatives respondents felt might ameliorate existing services and conditions. These might involve NHS-provided institutional services, local authority-provided residential services, or community based or domiciliary services. Questions like this offered an opportunity for respondents to put right (in theory) what they saw as being wrong about current provision - and therefore provided an opportunity at the stage of analysis to cross-check responses on views about current policies against views about 'best-possible' scenarios.

Finally, I hoped to set respondents' answers into a policy framework: how far, the final section of the questionnaire asked, did respondents feel their organisation made clear the aims and objectives of its policies? Was there any sense of everyday activity being grounded in an overall policy framework?

At the outset of each interview, I knew what the overall structure of it would be and what range of responses I expected to obtain. However, I also expected that during the course of administering the interview it would be necessary to adapt it or add supplementary probes to cope with variety of experience and,

perhaps, reluctance - or over-readiness - to discuss some of the issues.

A pilot study was conducted to test the appropriateness of an early version of the interview schedule. Thirty interviews were conducted with a range of respondents (similar to those included in the main study) in a third health board district in Scotland. From this, I learned that it would be important to impose limits on the extent of discussion in relation to the open-ended style of the questions to be asked. It was tempting to digress from the central research issues and to wander down interesting - and frequently illuminating - paths which had only limited bearing on the research questions. There was a continuous need to balance the possibility of obtaining further relevant illumination against the disadvantage of generating so much information that it would be impossible to handle during the analysis stage.

But I also found that on occasions it was necessary to modify the format - either by being more persistent in discussing certain issues or by downplaying certain others because they were inappropriate. Some junior level staff - district nurses, for example - might not find it easy to discuss some of the policy issues because they had never had to articulate their views in that way before. They, therefore, had to be encouraged to talk about the issues by sympathetic probing. In some interviews - mostly, again, with junior level staff, or perhaps with GPs -

questions about such things as the details of resource allocation policies were sometimes found to be too specific for respondents to cope with. In others, questions about personal details (career, experience of caring for dependents) were unwelcome, although rarely rejected.

During the course of the main study, these technical problems were also present; the interview format had to be adaptable and flexible in order to cope with the variation encountered. There were two further difficulties: first, a small number of senior medical respondents found it difficult to respond in personal terms - not just in relation to the personal questions, but to the policy issues too. They tended to respond in an 'academic' manner: that is, they did not say what they, as individuals, felt about an issue; rather, they tended to summarise the available evidence and then put forward the 'accepted' view about it. Second, a small number of other senior respondents displayed significant sociological awareness; they understood the research issues and the relevance of particular questions and tended to frame their responses accordingly.

There were a number of practical problems, too, which arose during the course of fieldwork mostly related to arranging the interviews. There was no difficulty in obtaining agreement for access but difficulties arose sometimes in trying to set the interviews up. Formal agreement for access was obtained at the most senior levels. In the case of the health boards, the aims

and methods of the research project were discussed with the area executive groups of each board and formal permission was granted with undertakings from both AEGs to inform the hierarchies of each profession below them that access had been agreed. In the case of the social work departments, the research protocol was submitted to their research liaison groups, discussed and agreed. The hierarchies of officers and field staff were then informed that access had been agreed.

Formal agreement at the top meant there were no formal difficulties lower down the organisational structures. However, it was often difficult to contact field staff and arrange convenient times for interview. I encountered some of the same problems that field staff themselves frequently mentioned during the course of interview - the problem of contacting field staff of different agencies because of ignorance of the times when they were likely to be in the office close to telephones and so on. In addition, such staff (as will be seen in their profiles later) tended to define their daily activities in terms of how busy they were and under how much pressure they felt themselves to be; calls upon their time (of more than an hour) were thus seen sometimes as uncalled for demands on their time. Once in the interview situation, however, respondents were generally eager to talk.

With more senior staff, it was a question of getting through the secretaries and administrative officers who often surrounded them

in order to fix times in their diaries for interview. Once the interviews had been arranged, they were sometimes postponed because of more urgent and important demands on senior staff's time cropping up. And during the interview, in certain instances, the interview had to be called to a halt and set up again for another occasion because of crises developing which had to be attended to.

In the case of a number of the hospital consultants interviewed, there was some lack of understanding of what was required of the interview. Once I was taken into the staff canteen where we had to perch on chairs at the corner of a table and where the respondent felt we could 'have a chat'. Another time, I was shown over the small hospital where the consultant was based, introduced to patients, given a cup of tea and put in a side room off the theatre and asked to wait until the consultant had gone into theatre, completed a laparoscopic examination of an elderly patient and then returned, still in theatre gown, for the interview.

No respondents who were approached refused to be interviewed. Only one of them declined to have the interview tape-recorded. One middle management respondent requested a preliminary meeting before the interview to discuss the research and to ask about how much of her staff's time would be taken up when I came to interview lower down the organisation. As in many interview studies, I encountered a readiness to talk very freely and

frankly, often about personal matters and often about professional matters which frequently related to other individuals who were also in the sample. This raises a number of moral issues relating to the research process, written about elsewhere (Dalley, 1988c). It requires the researcher to behave with extreme discretion during the period of fieldwork, but it also has implications at the writing up stage of the research in relation to the sort of information and evidence that can be used publicly. The obligation of the researcher to the research subject is of central importance.

Analysis

The interviews, as described above, were semi-structured with predominantly open-ended questions; while they followed a common schedule, questions were tailored to suit the profession and position of the respondent concerned. Inevitably, respondents varied in their readiness to talk: some were loquacious and expanded points that others were content to answer briefly. Some talked at length on issues with which they were familiar; others were more inhibited. Both the extent of experience *and* individual personality had some bearing on the type of responses given. Some interviews were completed in an hour; others extended to more than two hours.

The wealth of material gained and its variability presented problems for analysis. The mass of qualitative information had to be converted into systematic data; patterns and ranges of responses had to be looked for, identified and classified. The interview schedule had been drawn up to pose certain questions but the patterns of responses which they were likely to produce were not systematically anticipated in advance. Classification of responses had to be undertaken 'from scratch' after the interviews had been conducted. To take an example: on the issue of family/state responsibility, the question was posed in broad terms - 'what is your view about the relative positions of family versus state responsibility'; looking at a broad range of

responses, it emerged that they fell into five categories - primarily family; family with professional support; 'can't generalise/don't know'; partnership between family and state; primarily state. Once that range had been established, responses from all the interviews could be classified accordingly.

The process of establishing the classificatory categories was accomplished by taking a sample of 40 transcripts (that is, just over one sixth of the total) and scrutinising them with extreme care and in great detail. Notes were made on two series of index cards - one recording details about each individual's pattern of responses, the other recording issues as they occurred from all 40 interviews. The range of responses to any one specific issue was assessed and classified as in the example cited above. Thus the issues of inter-professional differences, constraints on daily work, acceptance of the priorities policies, views on prevention, community care and many others were explored, the range of responses recorded and appropriate coding accorded. This process has been outlined and discussed in a series of (unpublished) working papers (see, for example, **Appendix II**).

The mass of items cropping up were gradually pared down to manageable proportions so that a coding index could be constructed. Any researcher dealing with a mass of qualitative data is faced with the problem of selecting out the salient details without losing the residue of substantiating or illustrative data; a mechanism has to be devised for safeguarding

- or salvaging - the latter at the same time as constructing an index of the central issues.

A coding index was therefore constructed from the analysis of the 40 transcripts covering a total of 156 variables (see **Appendix III**); at the same time, other, residual, details were noted on a separate sheet for each respondent (see **Appendix IV**). This latter sheet included details of respondent and transcript page number as well as issue, so that it would be easy to refer back to the original transcript when necessary.

The long process of scrutinising all 236 transcripts began. It was necessary to look not only for responses relating to each of the variables but also for those relating to the issue sheet as well. In this way I built up a record of each respondent's views relating to the central issues (according to the coding index), but also to the subsidiary issues which were seen as important but not necessarily as central.

Although initially the coded data were entered onto a computer, I wanted more immediate access - especially to the responses of individual members of the sample. I decided that it would be more useful to enter the coded variables onto squared paper so that I could handle them directly - reading off the responses of individuals as well as groups of professionals. I therefore constructed a matrix consisting of the variables along the

horizontal axis and individual respondents, clustered into professional groups, along the vertical axis (see **Appendix V**).

In this way I was able to build a picture of how particular professional groups responded but at the same time was able to look within those groups at the spread of responses amongst individual respondents. This enabled me to take a number of 'cuts' at the data; I was not restricted to looking only at the larger groups. I could look at sub-sections or clusters of individuals within the larger groups.

Nevertheless, although the process of classifying and indexing had set aside an enormous amount of material, the wealth of data still remained. For the purposes of this thesis, it has been necessary to focus on particular aspects at the expense of others, purely because of the difficulty of handling an excess of qualitative data. Rather than looking in detail at professional responses to the policy issues, I have concentrated on the theme of professional ideology and the factors which cut across the centrality of such ideology in determining professional attitudes.

The pattern of the following chapters revolves round this theme. A series of professional profiles will be presented, summarising the main pattern of responses to the range of issues central to the study. These profiles will then be considered in the light

of the initial propositions underlying the study and others relating to the determining influence of professional ideology and other factors.

CHAPTER FOUR

PROFESSIONAL PROFILES: NHS RESPONDENTS

The findings will be presented in two chapters which will be concerned with presenting the data descriptively in a series of professional profiles (health service respondents in the first chapter, social work respondents in the second). These will be followed by a third chapter which will examine the findings more critically and analytically, in the light of the three initial propositions - the existence of a professional ideology; locational differences; and inter-professional variation - along with any other intervening factors which might emerge from the analysis.

Profiles of nine professional groups will be described by presenting each group's pattern of responses to a series of topics, all considered in the same sequence. Groups which are part of the health service will be presented first: doctors (consultants and then GPs), nurses (hospital nurses, district nurses and health visitors) and health service managers or administrators. Social work respondents will then be considered: social work managers, senior social workers and lastly basic grade social workers. A series of tables illustrating responses to the main issues in terms of broad frequency distributions is

contained in Appendix VI which can be referred to in conjunction with the profiles

CONSULTANTS

Twenty-three consultants were interviewed, most of whom worked in specialties related to the care of dependency group members - geriatrics, orthopaedics, rheumatology, psychiatry.

a) The moral dimension

A group of questions was asked, all relating to the central issue of where does individual and family responsibility for caring for dependent members of society lie, and where do the boundaries of state responsibility fall. In addition to a direct question about the balance of responsibility, questions were also asked about whether public expectations of the services available were too high, and whether, in the view of the respondent, members of the public were generally prepared to take responsibility for dependent relatives. Questions about the role of the voluntary sector were also asked, in the light of current government policy to involve volunteers (both organisations and informal caring networks, such as relatives, friends and neighbours) in the provision of community care. On the family/state responsibility question responses (for all respondents, not only consultants) lay along a continuum from 'primarily family' through 'family + professional support' to 'partnership between family and state

(via its professionals) to 'primarily state'. In the particular case of consultants, most adopted a moderate attitude (i.e. lying in the middle rather than at either end of the continuum) towards the relative responsibilities of state on the one hand and individuals and their families on the other. The views of a consultant psychiatrist were characteristic:

> It's a social responsibility I think. But then it's - well, for centuries, I think that - I think that most people realise that. (41JK)

Responses varied though. There were those who felt that families should bear primary responsibility for their dependent relatives:

> I don't know that I have a black or white view on that. I think, I do think that the family are responsible for their relatives - but whether they can cope with that responsibility is another matter.
>
> (Consultant psychiatrist 10JK)

However, at the other end of the continuum and in contrast to respondents from some other professions, there was none who felt that fundamentally it was the duty of the state to provide support. Most consultants though felt that it should either be a partnership between state and family or that the family should take prime responsibility only with sufficient professional services is support. A consultant rheumatologist, for example, said:

> If things were ideal, which I am not sure they are, it is a family's responsibility to care for the family unit.... some people do opt out...we do care but we only care for the

things that we choose.... I think that at the end of the day we have to, as a society in general, recognise that and say that if we are going to have a society which is going to be a caring society for its individual members in individual families, then we have got to help people to that end. It's not a matter of helping them to that end when the crisis happens. I think the whole thing starts at a much earlier stage. (105AB).

Like all other professional groups, a majority of consultants felt that the public in general expected far too much from the professional services:

I think maybe the majority do have aspirations [of the services] which I think are a little in excess of what is possible at present. I think that they have been educated to these aspirations. (Consultant surgeon 21DW)

But more consultants than many other professionals felt that they did not and that some even expected too little. Further, it seems clear that many of the 'expect too much' responses were in no way judgemental - the consultant surgeon mentioned previously continued by saying:

I don't hold any blame to anybody for that.

Respondents realised that the public's expectations were legitimately high: it should be part of the welfare state's responsibility to be able to provide services for all those who needed them. In addition, most consultants felt that people generally were prepared to take responsibility for their

dependent relatives, with a minority disagreeing. However, some respondents felt unable to generalise about these issues either because they did not have enough knowledge about what happened in practice, or because they found it difficult to be precise: in their view some people did care and did not expect too much and others exhibited exactly the opposite characteristics.

Another component of the moral dimension is the role of the voluntary sector in the provision of care. Support for its role may reflect a principled view that it *ought* to have a part to play, or it may simply imply a pragmatic recognition that help from anywhere, at a time of resource scarcity, should be welcome. A substantial majority of consultants supported the role of the voluntary sector but were outstripped in their support by all other professional groups apart from NHS managers. Of those supporting it, most said they were in favour of it as long as it was supplementary to the professional services - that is, they did not favour it as an issue of principle; and indeed a number of them expressed reservations about the danger of voluntarism encroaching on professional territory or about its lack of competence to act in expert fields:

> In the absence of a proper 'involuntary' sector, [the voluntary sector has] a fairly large one [role] but unfortunately the voluntary sector only wants by and large to do the nice things and there are lots of nasty things to do.
>
> (Professor of Geriatric Medicine 47JK)

Consultants then did not adopt a highly moralistic stance on the issue of responsibility as compared with some other groups. They saw an important role for the family and the individual, but not in competition with that of the state, especially as represented by its professional agents. They were wary that the voluntary sector should not step on professional toes or that its role be elevated to an article of dogma.

b) The priority policies

As noted in earlier chapters, central government since the mid 70s has advocated priority for the dependency groups. A series of policy documents has stressed this, although for the most part they have given no absolute directives as to how this should be accomplished. In this fluid environment, the attitudes of those who are required to implement the policies might be crucial. Consultants when questioned were not enthusiastic about the policies - very few supported them firmly (and more than that number *disagreed* with the policies) although half agreed with some degree of equivocation:

> I think that in health service planning that that's acceptable [conferring priority] and I think that it's happened. I think that the financial constraints however have got to be seen as separate in this. In any period of financial constraint, however, public opinion is going to swing back to acute medicine.

And even where there was endorsement of the policies, there was little agreement as to which sectors should lose resources in any reallocation. Less than a quarter of consultants felt that resources should be transferred from the acute sector whilst almost half could not make any choice at all:

> I'm not sure that they should be given absolute priority. I get slightly concerned if they say they're going to take their finances and staffing away from acute services - but I'm not so certain that these - the very very specialised acute services should have all the funds.
>
> (Consultant psychiatrist 19JKE)

This is, perhaps, especially significant because the respondents were consultants dealing for the most part with chronic conditions - and yet they were still prepared to acknowledge the pre-eminence of others' claims:

> The point is you've got to pay for the - the care of - er - somebody's got to earn the money to pay for - pay for the care of these people and if someone's got an orthopaedic complaint that's keeping them off work in the working age group - these people have got to get back to work and get into employment as soon as possible.... It's got to be the acute sector as well. (Consultant surgeon 08JKE).

They talked about acute medicine as pushing back the frontiers, of trailblazing - activities which should not be curtailed. Almost a third felt strongly that no sector should lose; that priority could only be given by the input of new resources.

This reluctance to be decisive in choices about resources is matched by a reluctance to single any one dependency group out for priority. Over half the consultants were unwilling to do so:

> I don't think so, although one might from time to time have to select a priority need on an individual or group, small group basis, but I don't think we should identify centrally a special group. (Orthopaedic surgeon 17DW)

Of the remainder, most chose the elderly, followed more specifically by the *confused* elderly, then the young chronic sick. The mentally ill as a group came low in the order of ranking and the mentally handicapped did not figure at all (even though consultants in both specialties were amongst the sample).

If consultants were not overly enthusiastic about withdrawing resources from some sectors to give to others, was there any way of reallocating resources *within* the sectors dealing with the dependency groups to improve services? Again, the consultants did not appear to have strong views. Half of them were non-committal, with a third suggesting that reallocation might be a possibility - the remainder saying it *was* possible. Greatest support (from the third of the sample that made positive suggestions) was for greater collaboration (through better joint planning mechanisms and coordination of services) between agencies responsible for the care of the dependency groups. Along with this went a call for greater inter-professional collaboration. There was, however, little support for any transfer of resources between agencies:

I think it's either for health funding; I think it's clearly a health duty or not and I don't know why the great drama has to be made about transferring sums of money from the health board to the local social work people..... perhaps social work ought to be given more - perhaps Region ought to be given a bigger contribution from central government. Why is there this great play about it coming out of health board funds? (Consultant in mental handicap 108AB)

There was some small support for the idea that there might be a *single* agency (combining social work and long term care) to overcome some of the existing organisational difficulties:

I think that [amalgamation] is more possible, provided it's done on very ordered lines. And again clearly established aspirations. It's really just a question of definition after all. Why should they be separated?

(Consultant surgeon 21DW)

On the other hand, there were those who were stongly opposed:

No I don't [agree]. I think I would be against that. I think doctors as a whole are rotten at providing, for the the most part, rotten at providing recovery programmes, are excellent at providing services for patients who are very sick people, and also have a capapcity for people feeling ill.... but I'm very against doctors being involved in the, anything apart from acute patient care.

(Consultant psychiatrist 23DW)

There was only one suggestion that there be a greater move from institutional towards community care.

One of the arguments put forward by strategic planners is that resources should be put into preventive and health promotional activities in order to forestall increasing demands being made on the services in the future. But just as consultants were unenthusiastic about the transfer of services from institution to community or from one agency to another, they did not come out strongly in favour of any greater emphasis on prevention. One respondent thought it was 'nonsense' and a quarter were either hostile to or sceptical about the idea:

> I think prevention is a nonsense.....I think we are talking all this prevention stuff and not realising the implications of it. What are we're trying to prevent disease for, we've got disease pretty well under control. Are we going to try and prevent people dying or something?
>
> (Orthopaedic surgeon 21DW)

Of the remainder, most were mildly in favour, with a smaller proportion expressing positively favourable views:

> I said right from the start here that if I had money to put into work on alcohol problems I'd just put it into prevention. I wouldn't put any into treatment or other resources - that's a bit far-fetched, I think, but ..... certainly the amount of attention given to preventative medicine is slight.
>
> (Consultant psychiatrist 23DW)

c) Community care

The definition of the term community care is notoriously muddled (DHSS, 1981c) - for some, at one extreme, it means any form of non-institutional care and for others, at the other extreme, it means care within one's own home or one's family's home. And between those two definitions lies a range of other definitions - care given by non-medical and non-NHS staff, especially local authority employed staff; it may mean care provided in a range of 'non-institutional' settings (usually defined by size), such as group homes, hostels, or half-way houses. Or it may mean informal care rather than formal paid care (Bayley's (1973) care *by* as distinct from care *in* the community). Lastly some define it in terms of quality of care: *good* care being that provided in the community and *bad* quality care being provided in institutions.

Over half the consultants opted for the broad institutional/non-institutional distinction; that is, any form of care *outside* hospitals should be defined as community care. A hospital-based consultant in mental handicap, for example, said:

> I would not want to feel that we were outwith the community. Mind you, some people have often said perhaps the most deprived mentally handicapped are those that stay at home and there may be some truth in that. I wouldn't like to say the hospitals are so isolated from the community. (113AB)

The rest were evenly divided between community care as being in one's own home or anything outside hospitals and old people's homes (definition by size of setting). Their tendency to draw a distinction between hospital and community may reflect their views on the health service/local authority divide and on their lack of readiness to recommend a transfer of resources from institutions to the community. There was a strong tendency for them to see local authority policies as threatening to their interests, as encroaching on their territory. They wanted to improve their services rather than hand patients over to local authority services in the community. Another consultant in mental handicap said:

> I think we must put the blame where it lies, and that's with some of social work ... no, if social work had other ideas, I think they - they've got to put their cards on the table and - you know, I see no examples of anything convincing that offers a good alternative to the care we give children here.

Community care was seen to be less of an objective for them and did not carry the same connotations of 'quality' as it might for some other groups of respondents.

This attitude is reflected in their responses to questions about how current services should be improved. Over three quarters called for more and better health service *institutional* care - especially for the care of psycho-geriatric patients:

> I think right now [we should put resources] into more custodial care, for the elderly confused. I think the amount

of stress that they are giving their relatives, I think there needs to be a massive provision for that right now.

(Consultant pyschiatrist 10JK)

There was some small recognition of the need for improved domiciliary services (both NHS and local authority), but overwhelmingly they felt the need for greater resources being made available for institutional care. This of course links in with their lack of enthusiasm for the priority policies as a whole together with their willingness to cede priority to the acute sector. Theirs is predominantly a hospital-based view of the world where the traditional hierarchies and priorities of medical politics hold sway.

d) Working life

I was interested in respondents' views of their work and the constraints and difficulties that they encountered in daily life, since the concrete realities of work might influence their views. We were interested firstly in the sorts of factors that impeded or inhibited their accomplishing of daily tasks. Most (86%) consultants said they were faced with constraints.

They drew a picture of work being bounded by problems of scarce resources or of cuts limiting existing resources. This was their chief problem. Even so they did not sound as if they felt overwhelmingly hard-pressed (especially when compared with some

other categories of professionals). A consultant psychiatrist expressed it thus:

> I think practically nil - may sound rather unusual, but personally I don't have any pressures. What is not there cannot be made available by just worrying about it. (41JK)

Following this category of constraints came those relating to the nature of the work which they performed. Here they seemed to be concerned with the level of responsibility which as consultants they bore in relation to the wellbeing of their patients. But of course this weighty responsibility was also conceived of as validation of their superior status within the agency and therefore cannot be seen wholly as a constraint. Workload was given as a third burden or problem that they had to contend with - which is clearly linked to the perception of resource scarcity and cuts as being a problem to cope with.

In terms of working relationships, consultants said they found relationships with other consultants the most difficult. Sometimes this was to do with the relative status between different specialties - the specialties dealing with chronic conditions, especially in the case of psychiatry, finding they had less power and influence than acute specialties:

> I would regard us [the psychiatry division] as being rather perhaps poorly represented ... for instance on the medical advisory committee, we never seem to have a representative on there and this is voted for [by] consultants in the various hospitals ...they would always outvote the

psychiatric representative. (Consultant psychiatrist 112AB)

In other cases, it was personality clashes and differences of opinion that caused the problems. Other problematic relationships mentioned were those with social workers and GPs and mostly related to problems of outlook and orientation or organisational matters. Social workers did not seem able or willing to do what consultants wanted:

> Anyone [such as social workers] who has got a split commitment ...I think they just don't become sufficiently involved in the work of the team.... we didn't find it particularly satisfactory with the last social worker we had. (Consultant psychiatrist 10JK)

Relations with GPs were sometimes difficult and communication was poor. One respondent said that GPs tended to use the hospital as an extension of GP services and was irritated partly because of the misuse of the service but also partly because GPs had a different attitude to the profession of medicine:

> In this hospital we [have to] run a substitute GP service in the accident unit.....a third of the local practices use the emergency treatment service. Very extensive....But general practice and specialist medicine are run on an entirely different basis. I'm an employee of the state and they don't consider themselves to be employees of the state ...some people [some GPs] get pleasure out of having power, [by sitting on committees] by the two greeds that can destroy most professions, greed for power and the greed for money. And greed for power is not uncommon in medicine.

(Orthopaedic surgeon 44JK)

Enormous hostility was expressed by consultants almost without exception to social work as an agency. Whilst many respondents did not have a great deal of direct contact with individual social workers - and then only hospital-based social workers - they were often critical of social work in general. They felt it was badly organised, had the wrong priorities (that is, those that did not match theirs), differed in its orientation and misused its resources:

> I think there's probably a feeling that the social work department perhaps has mental health lowish down on its list of priorities... and I think there's perhaps a certain amount of misunderstanding or lack of information. I think I would say that the general understanding of mental illness by social workers isn't all that great.
>
> (Consultant psychiatrist 112AB).

Consultants also criticised the health board as an agency along with its officers. They felt they did not understand clinical needs and attacked them for adopting the wrong policies (for example on closures) for wasting resources and for being badly organised. A consultant surgeon, talking about hospital and health board management, said:

> Well, you catch me at rather an unfortunate time with that question....but after the redistribution of hospital management that meant that the main management move away from the

> hospital area where I'd been used to meeting them every day .... so that from that point of view I think it's a deterioration in the relationship and it just comes at a time when they've said they were going to close down surgical beds.
>
> (21DW)

Clearly, consultants were hostile to any professional group or any agency which failed to recognise their status, or tried to impinge on their territory (which should be protected, they felt, by their claim to clinical autonomy). Nevertheless, much of this seemed to be a 'received' hostility. Consultants seemed to be cocooned from any great contact with outside agencies or professionals. The world of the hospital was their world; the community was something removed, something 'out there'.

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GENERAL PRACTITIONERS

Nineteen general practitioners were interviewed; some in group practice and some singlehanded.

a) The moral dimension

The most striking feature in the GP profile is the strong, clearly defined position they take on the moral issues. It tends to be an abrasive and judgemental one. Along the continuum from 'primarily family' to 'primarily state' responsibility, the GPs concentrated heavily towards the primarily family end. Almost half saw it as a family duty to care with another third seeing it as a family duty but with professional support. Of the remainder, only a tiny proportion (a tenth of the total) felt that the state had an equal part to play (whilst none saw it as primarily a state responsibility).

Many respondents elaborated these views in their answers to questions about public willingness to care and public expectations. While they stressed their feeling that it should be the public who took on the burden of care, they expressed jaundiced views about what really happened in practice:

> Morally it should be the family but then we're not living in a very moral age. and the families just don't want to know

....The hard fact is that people really don't want to have this burden. (18JB)

A number said that many people had grown too used to the benefits of the welfare state; they looked for handouts and were not prepared to take on responsibility for themselves and their dependents:

I think there is generally an expectation that, you know, something will be done if anything goes wrong with a member of your family, the state will step in and take care of the situation. Yes, I think there is an expectation amongst society in general that things will be done, things will be taken care of. (13JB)

Some said that British people should take a leaf out of the Asian community's book: that *they* knew how to care for their dependents and to take pride in doing so. Thus a substantial majority (84%) said that people expected too much of the services and another majority ((67%) felt that in general people were not prepared to take responsibility (although in this case almost a quarter were not prepared to generalise on the subject). And many of these respondents judged the public harshly; they felt that people did not care and expected too much because they were morally deficient:

I wouldn't mind as much community [care] as you like if people wouldn't demand that I take the responsibility... I would say the majority opt out. Fewer and fewer folk are going to upset their own lives at all to cope with their own relatives. I think they're being selfish. (92AB)

Very few GPs were willing to recognise that force of social circumstances might be a factor in some people's apparent inability or unwillingness to care.

In the light of these perceptions of families' unwillingness to care and views that it should not simply be left to the state to take responsibility, it is interesting to look at GPs' views about the voluntary sector and its relationship to the professionally provided services. GPs were substantially in favour of voluntary effort - (although evenly divided between giving unconditional and conditional approval) - as long as it was seen as supplementary to the professional services. They saw it in terms of 'befriending' and standing in for a short time to relieve relatives or as bringing a 'touch of humanity' to the business of caring which professionals could not provide:

> Just people who can go round, even talking to people, just visiting. Don't have to do anything, don't have to go shopping. Even just to say hello to a lonely old lady makes all the difference, just being her friend. (15DW)

Whilst the moral views of an individual GP might lead him or her to adopt a position which emphasises family duty (and voluntary effort) rather than state responsibility, it seems clear from this evidence that in a practical sense that same GP still sees a major role for the professional services - either because families do not meet their responsibilities and therefore have to fall back on the professional services or because the voluntary sector is not seen

as being able to supply the skills and resources which the statutory services are able to.

b) The priority policies

A majority of GPs agreed with the priority policies; they divided evenly into those who agreed firmly and those who agreed but with a certain amount of equivocation. A fifth of all GPs, however, felt that any increase in resources coming into the health service should be spread across all sectors evenly and a smaller proportion (11%) stated that they actually disagreed with the policies. This spread of views is reflected in their responses to questions about which sectors should lose resources in order to fund the priority policies. Just over a third agreed that resources should come from the acute sector, but just under a third stated that no sector should lose. And almost a quarter of GPs were unable to say where the resources should come from.

A Glasgow GP was typical of many when asked if he agreed with the policies:

> I would think so. After all, it's supposed to be a sign of a civilised state to look after the poor, the ill, the handicapped and in that respect it must be right, yes.

But, when asked which sector should lose, he goes on:

> This is a Catch-22 situation. Well of course again nobody should lose resources.... well obviously the health service should be funded decently. (25DW)

Most responses - even those which were positive in one direction or another - were tempered with doubts or at least with recognition of the difficulties involved in making such decisions. They recognised the pressing needs of the priority groups, either because they dealt with many patients coming from those groups or because they saw themselves growing older and in possible need of the services in the near future. And yet at the same time, they found it difficult to agree that resources should actually be withdrawn from existing areas of the service. Even in relation to this set of questions, the moralistic views of GPs sometimes came to the fore. One, for example, condemned people for making ever-increasing demands on the service especially when compared with the elderly people he had dealt with when he first came into practice:

> I do blame them [elderly people today] and I don't know about other people but as a GP what I do notice is that old people of seventy and eighty today are not the same old people of seventy and eighty when I started... they're two different breeds ... the present lot expect to be kept as sixty year olds forever and you can't do it.
>
> (92AB)

The view seems to emerge that while there is broad acceptance that the dependency groups ought to be given priority, there is no great enthusiasm for the policies or for the re-directing of resources from some sectors towards them. Some expressed surprise that such policies existed, given current hospital building programmes focusing on acute services. And, indeed, there were some who felt that the acute sector should not have to lose resources:

> I don't know about priority. The acute sick should have priority. it would be very wrong if you could not have an acutely sick person admitted to hospital, because there were no beds, because they were all occupied by the chronic sick. There would be something wrong there. So I don't that they can have priority. (18JB)

When asked which dependency group ought to be singled out for preferential treatment, not one GP singled out mental illness or mental handicap for priority. They alone, of all professional groups under study, failed to mention both mental illness and mental handicap. It is perhaps significant to note that they are both conditions for which GPs are sometimes accused of overlooking. As it is, their preferences divided equally between those who singled out the elderly and the confused elderly or those who felt no one group should be singled out for preference. Broadly speaking, it is those GPs who supported the policies firmly who singled out the elderly for preference and those who were more reluctant to support the policies who went for the 'no distinction between priority groups' option.

Whilst it is clear that there was a distinct lack of enthusiasm for a positive policy of *withdrawing* resources from particular sectors, it is interesting to note that a substantial majority of GPs - almost three quarters - felt that better use could be made of existing resources and that almost half felt that resources could be shifted between priority services (as opposed to reallocating *away*

from particular client groups or sectors) to good effect. Better use could be achieved by making savings on costly administration and management; on a rationalisation of services and on cutting out waste. This was consistent with GPs' impatience with health board management and administration in general; they felt there were too many 'faceless bureaucrats' who were unable to make effective decisions when GPs wanted them to:

> I think resources might have been better used. I think too, oh God, I think the administration is just appalling in the health service and I don't just mean locally here in Moray where it's fairly bad. I mean all over. Far too many chiefs and not enough indians. (14JBE)

and

> Stop this 'tiering' within the health service for a start. The amount of layers of administration ... too many committees that have to sit before anything gets done... I get six letters from perhaps two or three [consultants] in the same department. Why not send them all in bulk... there's lots of small things which doesn't sound very much but I'm sure they could trim if they tried. (20DW)

Where improvements could be made by shifting resources *within* the priority groups sector, a small number of GPs advocated a direct transfer of resources from one agency to another. GP hostility towards social work was reflected in the suggestions of a few respondents for the health service to take over local authorities' responsibility in the field of long term care:

> If there were to be cutbacks - back to the old subject again - I personally can't, wouldn't, see any great loss in the social work department disappearing completely. (91AB)

Others in less hostile mood suggested an amalgamation of health and social work services and others advocated improved collaboration between agencies. In only one instance did a respondent recommend a transfer of resources from institutions to the community.

GPs, like consultants, were not enthusiastic about the suggestion that more resources should be devoted to prevention and health promotion. Less than a third expressed positive support for the suggestion with another third voicing mild approval. On the other hand, more than a quarter were sceptical with the remainder actually being against the proposition:

> You still can't stop, you know you can't make patients prevent, patients still smoke; women don't get blood tests when they're pregnant to see they're having children with spina bifida...and some, if they do, are not willing to do anything about it. That's their decision; you can take a horse to water but you can't make him drink....I run a hypertension screening clinic for middle-aged males. But you may pick things up a bit earlier, but I don't know if you make any great difference..... no point in screening and finding something and not being able to do anything about it. It's just a waste of time and money.(14JB)

No other respondents except a few consultants and a very few social work managers actually spoke out against the idea of resources being moved towards prevention - and yet GPs are front-line workers one of whose expected functions is in the field of prevention and health promotion.

c) Community care

GPs in general define the meaning of community care in broad terms. Half of them believed that it relates to any form of provision outside hospitals:

> Well, community care is not so much within their own home. I would have said slightly within the community - meaning outwith the hospital basically.... It's really, community care to me is, does the patient have any independence left? And if they have, I consider that means to be part of the community. It's when they are taken in and are a paitent [that it's not]. (20DW)

and a third of them saw it as relating to any form of care except institutional (hospital) or residential (old people's homes) provision:

> Old people's homes and hostels are not within community care, but sheltered housing is. (42JK)

A much smaller proportion (less than one fifth) saw it as relating specifically to the person's own home. In this they differ from other community-based front line workers who were more ready to interpret community care as meaning care provided in one's own

home. And given the GPs moralistic views about family duty to care, and their emphasis on the appropriateness of 'own home' care, this may seem somewhat perverse. On the other hand, the distribution of their responses resembles that of the consultants, so it may be that they are both defining the term on the basis of their mutual medical orientation.

Most GPs expressed concern about existing community care provision but from two different perspectives. On the one hand there were those who felt community care had gone far enough because there was a limit to how much families were prepared to care:

> I think it's gone as far as it can, given human nature.... there are certainly situations whereby idealistically one could expect families to look after - in the community - their old relatives ... but I think it's wildly optimistic to think that people are as publicly spirited to look after those dependent folks - certainly friends and neighbours... even families, won't take on that responsibility. (13JB)

On the other hand, others said that current provision was not good enough and had to be improved - partly because it was just not adequate, and partly because people's expectations were very high:

> Out of sheer necessity... I don't think sufficient is done about allowances to relatives looking after people. I mean there are many people in our area - women working as home helps and their own parents have got home helps. Now it would be far better.... if their relatives were employed as caring for them. (42JK)

But although a majority wanted to see improved domiciliary and community-based services, at least half of them also wanted to see improvements in NHS institutional provision.

d) Working life

Most GPs (79%) indicate that they felt there were constraints on thair daily work, although by no means as many as in other professions - excepting hospital nurses (ward sisters). Their main concern was shortage of resources (just over a third commented on this). One saw this as a political issue:

> The only pressure we're under is a political one - of being in the situation where the politicians of all persuasions passively accept an unlimited demand and then proceed to ration our capacity to deal with it.... always the implication is that somehow or other, I don't just mean GPs, I mean all professionals, are the bad boys. (93AB)

Some of the concerns were to do with limitations on personal activity - limitations on the ability to do minor surgery for example. Others were to do with the effects of shortages in community-based provision which had knock-on effects for what the GP could actually do for patients and their families. This related in part to what facilities were available from social work departments and this leads on to considerations of GPs' working relationships with other agencies and other professions.

Half of all GPs reported difficulties in their relationships with social workers; this was where their chief problems lay. And even where they did not report difficulties with individual social workers half of them found relationships with social work departments difficult. Most of the problems in both cases centred on differences in professional orientation or on organisational differences:

> We tend to stick a little bit and think it's only medical - stick to our nurses and our health visitors and call in the social workers where there's definitely less medicine in it and keep them at arms length. Sometimes what happens is you refer something and before you know where you are it's been referred back to you and multiplied ten times over. (28JK)

and

> Doctors and social workers - again you vie for whether a problem is a social or a medical problem.... to establish precedence there. (13JB)

They also reported inter-professional differences with consultants, but in this case these were tempered by almost twice as many reports of good relationships with them. The differences centred on organisational problems rather than on differences in professional outlook - for example in relationship to the shortage of hospital beds for severely demented elderly patients and the supposed reluctance of consultants to take such cases 'off the GPs' hands:

> The one group of patients they [consultants] don't want to

> get involved in is basically the purely psycho-geriatric and these are the patients whom they might not accept ... there is one [a psycho-geriatric unit], it started in the south-west district a few years ago and it's tiny. I think I've only had about two petients admitted to it in the past five or ten years. (42JK)

This clearly is the reverse side of the consultants' complaints about GPs using the hospital as an extension of their own services. On the other hand, a number of GPs declared themselves well-satisfied with local consultants, singling out on occasion particular consultants:

> They're extremely good. And if they can help they will. It's not a policy of 'Oh I can't be bothered or I don't want to'... if I wish or request a home visit to an elderly patient, there'll be somebody out that day or the following day ... that particular consultant will phone me back and say exactly what she saw and exactly what she's going to do about it. We've got a very good relationship with the geriatric unit here. (20DW)

Consultants are not the only groups of professionals that GPs got on well with. They registered positive responses with regard to their relationships with district nurses and health visitors (although the reverse was not quite so true). In general, these positive feelings towards district nurses and health visitors tended to reflect a rather paternalistic relationship between GPs and the two nursing groups, which was not necessarily reciprocated:

> The idea is nowadays that district nurses are no longer attached to doctors but are actually an autonomous group and they do their own thing. I think it only works because we have very good district nurses here who think that's a load of rubbish and still liaise with us very closely....the ones we have are such stong personalities that it would take a lot ... to flatten them [action by their nurse managers]. (16JKE)

And GPs did not hold these same warm views when nurse managers came into the picture; that category of nursing staff - along with other health board officials - was seen as a constant bugbear:

> I think they tend to feel that those who can, do, and those who can't, become administrators.... they think that the only way to do nursing is to sit behind a desk and tell other people what to do... I think the local nursing administration doesn't have a good name amongst any of the GPs. (16JKE)

But, as they frequently stressed, GPs are independent contractors, outside the formal management structure of the health board. It is perhaps inevitable that they adopted a position of being critical of and sometimes hostile towards those parts of the health service with which they have to relate but over which they have no control. Where they are in a position to exert influence (if not formal control) over parts of that service, through district nurse and health visitor attachments, they exhibit positive views. As gatekeepers to the rest of the service and to other services too,

this mix of hostility and paternalism may be unfortunate - especially when the strong moralistic views about family duty are also taken into account. A patient approaching the GP as first point of entry to the maze of services being sought, is likely to meet a set of very preconceived attitudes about what may or may not be appropriate.

HEALTH VISITORS

Twelve health visitors were interviewed.

a) The moral dimension

On the moral issues, health visitors displayed a mix of collectivist feelings tempered by a knowledge of what happens in practice. Almost half believed that it was the duty of both state and family in partnership to provide care for dependent people. The remainder veered towards family responsibility - although with professional backup:

> I think the family first and foremost with help from the state. I mean I can see the problems, you know, for the family and all the rest of it but I do feel that anyway you can't wash your hand altogether of your dependent relatives.
>
> (07JB)

They tended to be more collectivist in their views than consultants and considerably more so than GPs, who, it has been seen, were heavily convinced that it was a predominantly family responsibility.

Like GPs, health visitors felt strongly that people expected too much of the services, but they were less harsh than GPs in their judgements as to whether people were prepared to take responsibility for their dependents - they split evenly into

those who felt thay were and those who felt they were not. Some of them saw and appreciated the difficulties that people caring for dependents had to cope with but judgemental views did creep in. Some felt that people were too dependent on the welfare state: they had become too used to 'state handouts':

> They have a high expectation of any kind of service that's supposed - they do think that the state should provided.... But in this are, the dependency on state aid is vast and they do an awful lot of taking and not a lot of giving, I'm afraid. (20JK)

Health visitors in general place stress on the individual's responsibility in maintaining health - views about expecting too much of the services may be linked to this perspective. Those who felt that it was primarily the family's responsibility to care tended to be the ones who felt the public expected too much although they were divided in their views as to whether or not the public in general was prepared to care.

Health visitors stand out as being wholly supportive of the voluntary sector; all of them favoured voluntary input, either unconditionally or under limited conditions:

> Well, I think we'd be lost without them [voluntary groups]. Um - we'd be very lost without them. I think they do a super job. (10JKE)

However most saw the voluntary sector very strongly as providing supplementary activities:

> Well that [the role they should play] depends on the

professional people that are looking after them, what help they need. I should imagine they would be able to say what they would like voluntary groups to do. (26JK)

- and there was one lone suggestion from a respondent who was otherwise in favour of the voluntary sector that the motives of some volunteers might be suspect:

I think volunteers used for anything need to be particularly well screened. Sometimes people volunteer - ehm - for reasons .... what I'm trying to say is, if you applied for, say, volunteers to do bereavement visiting, you may well get people who've been bereaved themselves and of course they think they understand what's going on.....I would say that volunteers are very, very necessary but... who does the .. I don't know who does the screening. (86AB)

Health visitors, some would argue, are concerned with offering 'appropriate' models of how family life should be conducted (albeit in a supposedly non-directive fashion); the views of one health visitor about the resistance of some people to change their attitudes is perhaps characteristic:

Int. Are they [the public] changing their attitudes towards the dependency groups?

Resp. Not amongst the lower social classes. I don't see them sort of changing their attitudes. I think, perhaps their attitudes to child rearing, you know hopefully, you know, they're listening to us and taking it all in. (07JB)

Their practice, therefore, is likely to be underpinned by moral considerations. It is thus not surprising that they hold principled views on the issues of family and state responsibility as the evidence demonstrates.

b) The priority policies

The priority policies were well supported by health visitors. Almost half supported them strongly and an equal number supported them but with some degree of equivocation:

> Yes, [I agree] because they are behind and I think they should be brought up to date. I really think that (20JK)

but

> Well I could answer this in two ways. In one way I agree, yes. I think our hospitals for instance are still far too much geared for the acute sector.... But when it comes to the importance, then the emphasis , no. I think the emphasis must be on the young who are going to be the society of tomorrow [who will] look after all the dependency groups. (14JK)

None opposed the policies although there was some very small support for 'balance' - that is, resources should be spread evenly across all sectors. Support for the policies, however, must be said to be tempered when responses to the question on which sectors should lose resources are examined. A third of resonses suggested that resources should be taken from the acute sector:

> Right, I would cut that [high tech surgery], yes, definitely. I mean there's the expensive angle, for one thing. I know it's a very emotive subject, but yes [I would cut that]. All right.... we're getting on to rather dangerous ground! (83AB)

But half said either that no sector should actually lose resources or that it was impossible to make a choice:

> Well, I think, you know, there's - the resources have to be allocated pretty fairly and squarely across the board, you know, because there's not just the elderly [and other dependency groups] to be considered...there's nursery schools for instance, we're desperately short of nursery schools and day centres for children at risk and things like that. (07JB)

It is important to remember that health visitors do not have to make decisions about the allocation of resources in the course of their work. It is relatively easy for a practitioner, unconcerned with the problem of budgets, to favour one policy or another; it is more difficult or a more unfamiliar exercise to decide on the mechanics of that choice and to say from where resources should be withdrawn. Where health visitors do have to make choices it is a much less explicit procedure than making budgetary decisions; it is likely to be concerned with caseload choices and those are often complex matters concerning a mix of personal preference and untested judgement about client need.

In terms of stated preferences for policy priority (as opposed to individual work-pattern choices), as many health visitors

favoured priority being given to the elderly as said no one group should be singled out. Others favoured the mentally handicapped and physically handicapped + young chronic sick; but none favoured the mentally ill. It is perhaps worth noting that they chose first of all a category with which they themselves are largely unconcerned - as opposed to mentally handicapped or physically handicapped young people with whom they do have dealings.

Half of the respondents favoured a redeployment of resources within existing services. For almost all, this meant greater collaboration in provision of services between agencies responsible for the care of dependent people rather than a total transfer of resources from one agency to another. No health visitor mentioned the possibility of transferring resources from institutions to the community. Almost all the respondents favouring greater collaboration thought that an amalgamation of the two responsible agencies might be a way forward.

But in spite of the emphasis placed on greater collaboration, more than half the health visitors expressed sceptical views about the possibility of improved collaborative relationships. Almost all those favouring collaboration were sceptical about the possibility of success:

> I think there could - an amalgamation might be quite a good idea. [But] again, that might lead to problems. It reminds me of the Jay report, the talk about social services taking

over. I think there was quite a bit of fuss about that, particularly the nurses felt that they would be taken over by social workers..... that's the sort of problems I would see, there might be difficulty with people joined together, there might be some disharmony. In other ways, it might mean that money is maybe spent more realistically or used better. (27JK)

Far more positive were the responses given to the question about prevention. Almost all supported a greater role for preventive and health promotion policies - by these they meant, first, health education, followed by technical or interventionist strategies such as screening and immunisation/vaccination and the like. But the problem of changing public attitudes was not under-estimated:

I think the health service has not developed as it was planned; it's not a health service, it's an illness service. And we're not a healthier population at all. People have forgotten how to look after themselves and how to doctor themselves, I suppose, and it needs to be changed, people should be made aware of their own responsibilities...perhaps if people were better educated... (10JKB)

and

You've got to change people's attitudes and I'm afraid we've now got to retrain them to thinking prevention and I think it will take a while. I think it's beginning to come but I think it will take a while.....I think what's happened is,

we've now made a nation of people who are dependent. (11JBE)

The overwhelming support for preventive work is not surprising. The tenor of health visiting policy and education in the 1980s is based on a view of health visiting as being about the promotion of good health; its surveillance role is underplayed, although implicit in much of its activities and high on the list of key concerns at the level of practice and professional standard setting.

Just as much as they supported greater emphasis on prevention, health visitors believed that better use could be made of existing resources; in this they held stronger views than most other groups. They did not express strong feelings on where improvements could be made however, although suggestions focus on the rationalisation of services and on savings in administration - one suggested savings could be made within hospitals but not in the community (where, of course, health visitors are based). There were some perhaps rather judgemental suggestions like the respondent who suggested that women should have to pay for abortions:

Int. Is there anything you'd like to see cut out in terms of needless use of resources?

Resp. Right. I would make everybody pay for their abortions. They ought to. (83AB)

and also the respondent who suggested better use could be made of home helps by restricting their use:

Well, home helps for instance, although in some areas super-

vision of the home helps is very good, there are areas where home helps go into people who really, quite frankly, could do a lot more and should do a lot more for themselves. I think an attitude has sprung up in some people's mind that once people reach a certain age they're automatically entitled to to a home help. And of course that is not so, it's according to need. (14JK)

c) Community care

Health visitors' definitions of community care were varied. A good proportion - almost half took it to mean care outside hospital:

I'd say it [community care] would also include old people's homes; that is quite different from being in hospital. (07B)

But the remainder divide between 'own home' and anything outside institutions such as local authority old people's homes as well as hospitals:

I think it's maintaining people in their own homes. (26JK)

While they supported central government's policy in principle, it is interesting to note that the sorts of improvements in services which they advocated tended to focus as much on institutional and residential services as they did on community-based services - and very little on domiciliary services:

I think the geriatric wards should be expanded. I think they

should be expanded for the simple reason that they are going to be needed. There are always going to be an awful lot of people who cannot be cared for in the community.... I think the whole side of geriatrics should be expanded and given more funds. (20JK)

They did not seem to have any comprehensive and coherent picture of what community care might look like with improvements. This may indicate their fundamental lack of interest in the dependency groups; their professional concern was with the progress that clients could make, especially towards good health; dependency groups are characterised by the long-term chronic nature of their conditions

d) Working life

Nearly all health visitors reported that they work under constraints and that those constraints were predominantly to do with workload:

I suppose we've always got too much work. I think that's just a common - I find, you know, the sheer travelling around the practice, you know it's difficult to get round just as much as you would like to do, or devoting more time to, you know, the other dependency groups. (07JB)

This feeling of stress in the face of demand made on them is compounded by a feeling that resources are too scarce or are being continuously cut. They saw demand rising constantly and yet they and their colleagues were unable to meet it adequately.

In addition they reported problems in relationships with two groups of professionals with whom they have to work very closely - namely, social workers followed by GPs. The complaints were numerous and related in both cases to problems of orientation (especially in relation to issues of diagnosis and treatment/care):

> There's a sort of grey area between health visitors and social workers....There's an overlap.... I think a certain amount of it's inevitable when you're dealing with people but I think there could be closer links, I think particularly during their training period.... we're not really aware of what the other does, from both sides (84AB)

and organisation (inability to make contact because of the way things are organised, or difficulties in getting decisions made in the opposite organisation or setting):

> When the communication is good, the relationship's good. When the communication begins to break down to the extent where I have to phone four times and visit once to the social work department simply to try to set a date for a case conference and it ended up on the phone doing my nut telling the one particular social worker involved exactly what I thought of them, then that's not so good. (20JK)

In the case of GPs, there was sometimes resentment at the way GPs regarded attached health visitors:

> Occasionally in conversation we hear them talking about 'my health visitor' which irks rather but they're well aware

- I think - of the fact that we're employed by the health board and we're responsible to our nursing officer. (84AB)

And sometimes there were feelings that some GPs did not want to be bothered with health visitors at all:

> The old old family doctors..... I don't think, I don't know whether nobody's bothered to explain to them what a health visitor does or whether they just don't like the idea of yet another person to consider..... I don't tend to get an awful lot of cooperation. I don't mean that they're generally obstructive, just that they don't refer things. They don't refer their elderly, which they could do. And they don't refer their handicapped, which they could do - handicapped outwith the age group that I would know about. (20JK)

Relationships with other professional groups were, on the whole, amicable. Health visitors reported positively on relationships with district nurses in particular and this was reciprocated. Conversely, relationships between social workers and health visitors were often thought to be problematic by both sides. In the case of GPs, however, it was noted earlier that GPs themselves generally viewed health visitors in a benign light. The paternalistic attitudes of GPs tended to make them impervious to the real feelings of frustration that health visitors often felt towards them.

DISTRICT NURSES

Twelve district nurses were interviewed.

a) The moral dimension

District nurses, of all health workers, have perhaps the closest contact with heavily dependent people at home 'in the community'. They see the consequences of early discharge policies and strategies designed to keep people from moving into hospital for long term care. They are conscious of the needs of those people but at the same time are amongst the first to feel the pressure made by those demands.

Almost half (only slightly fewer than GPs) felt that it was primarily the family's duty to take responsibility:

> I think the family actually, primarily. Definitely. After all, it's their parents or whatever, or wife. And they should take the prime responsibility. (14JKE)

and

> I feel it should be the family .... I think an awful lot of the people nowadays just consider that it's the state that should be responsible for their frail elderly relatives. (35JK)

Another quarter agree with that view but also stress the importance of professional support:

I think families should take responsibility - I think it's your mother or whatever. But that said, I'm not saying that if it's your mother get on with it, I'm not going to have anything to do with you. We're here to help the family, not take over from the family. (87AB)

A third saw it as the duty of the state and family in partnership:

I think it's a happy balance between the two - I don't think the family should ever be left totally in charge of an older person because I think older people can sometimes be rather difficult to work with. I think we're often very ready to criticise a younger relative if they don't look after an older person but we don't realise that maybe the patient is incontinent, maybe they have ways that irritate the family as well. I really think that it's just a balance between the two. I don't think it should be either one of the other. (29DW)

Thus they were more 'pro-family' than health visitors but less extreme in that direction than GPs. And yet while they saw caring as a family responsibility, they tended (just over half) like GPs to have a relatively jaundiced view of the public's *actual* willingness to take responsibility:

No, you find most of them try and avoid... you get the odd one that's always left with her mother, or whatever, or they'll say that they've never been used to anything else. But if it's maybe an elderly couple and maybe the husband's died and the wife's there - the daughters or the sons, they

don't really want to have them, you know. (08JB)

On the other hand, they had more moderate views than both GPs and health visitors on the question of whether the public expects too much of the services:

I don't think so. There's always the minority that'll always want more but to be truthful, the majority of patients are very grateful, they think they're getting a lot. (15JB)

Nevertheless, almost two thirds did think that they did expect too much, but this is fewer than their GP and health visiting colleagues.

Again like their colleagues, they favoured the idea of voluntary sector involvement although less wholeheartedly than health visitors - but similarly only as supplementary to professional involvement:

Oh I think they can do an awful lot of good work in the way of - not nursing, but occupational therapy, that type of thing, libraries, these cassette libraries, gardening, decorating, hairdressing, driving people places, organising concerts and entertainments, taking them to hospital appointments - there's an awful lot for them to do. (17JB)

Any idea that voluntary effort can replace or supplant professional activity (for example as a means of cutting costs) would be unlikely to have the support of community-based professionals - although what constitutes professional activity might be contentious if the downgrading of occupational therapy in the last quotation is indicative of certain professional

views. One district nurse stressed the need for professional supervision of volunteers and described how on one occasion she knew about, volunteers had ended up costing the social work department a great deal of money clearing up mess they had made when painting and decorating for social work clients; she concluded by saying:

> I think it's great that people are willing to go and do, but I think they've got to be organised properly by somebody that knows what they're doing in the community in all aspects, to choose the right people for the right [task] - because again you can get somebody going in and say 'Right Mrs So and So,' and after four weeks they say 'Oh dear I've got to go' and they back out without getting somebody else to go in. (88AB)

b)The priority policies

After health visitors, district nurses of all NHS staff supported the priority policies most strongly. Three quarters of them registered support - mostly without equivocation. This perhaps is not unexpected because the policies are offering priority for many of the groups which are the primary concern of district nurses. But although their support was strong, perhaps more interesting is their indecision when it comes to having to make choices about which sectors should lose resources. Of all categories of respondents, they are the only ones who in *no case* selected the acute sector. A third said that no sector should

lose anything (that is, priority should only be given with *extra* resources) and the remainder were unable to make any choice:

> Yes definitely [they should have priority]...I mean it's hard for me to say [which sectors should lose] because I don't really know....I don't think there's enough resources going into the National Health Service for the community, but I would not like to say ..... [it would be] robbing Peter to pay Paul.....That's a question I wouldn't really like to answer. (15JB)

Inability or refusal to make a choice about the withdrawal of resources might be related to a number of factors. Distance from the point of decision-making may make it appear an irrelevance: outside the respondents' sphere of control or knowledge and therefore not a real issue to them although they may feel strongly in favour of aspects of particular policies insofar as they affect them in their daily work. They are deeply aware of the issues as they affect field-level working but too far removed from the decision-making which creates those conditions. Many categories of fieldworker may find this to be so. However if similar indecision was apparent in other cases - managers for example - who are members of the group which *does* have to make the decisions, such reluctance to make definitive choices might be a result of knowing the complexity of the issues too well.

When district nurses were asked about which dependency groups should receive priority over the others, three fifths of them

felt unable to single out any one particular group. Often, a respondent would start by suggesting one client group but then go on to included all the other dependency groups. Amongst the others, the mentally infirm elderly and the young chronic sick took precedence:

> Oh yes, the demented, there's no doubt about it. Any relative can cope with someone who they can have a conversation with and who can tell them what's required, but the demented patient, oh yes definitely, they need the most help and the most back-up services that they're not getting and they need the break, but they need a break much more so than the relatives who are coping with just the physically disabled. (15JB)

The unwillingness to single out particular groups perhaps fits well with the responses on the resource questions - in that they were unwilling in that case, too, to make clearcut distinctions between groups or sectors. Their perceptions about the global policy issues seemed limited and their direct knowledge appeared to be small. When questioned about possible improvements or different ways of allocating resources, one respondent answered:

> I've never thought about it, just never thought about it (86AB)

Further, it may reflect on the nature of district nurses' work. It is predominantly task centred; there is little room for personal choice and preference in constructing their caseloads. Referrals are made and district nurse input is assessed, allocated and provided in terms of tasks to be performed. Less

willing than health visitors to make choices, they were like health visitors in that none of them indicated any preference for giving priority to the mentally ill.

Almost half the district nurses felt there were ways in which resources or effort could be redeployed to greater effect within the chronic sector, although half felt unable to comment. Those who did saw this in terms of greater collaboration between agencies and between professionals:

> I think it would be quite good [to collaborate on joint projects] if they have the resources. But generally in the National Health Service doesn't have the money, the local authorities don't have the money either. But, yes, I don't see why it couldn't work. (35JK)

A small number suggested that services for the dependency groups could be amalgamated:

> I think yes perhaps you can amalgamate services. I think quite honestly you get questions asked you by community people asking you the difference between health visitors and social workers. Um, they do cross boundaries quite a lot and because of that happening, I feel sometimes perhaps you could integrate. (14JKE)

It is interesting that in the case of the district nurses, unlike some other groups, they also felt very positively about the possibility of collaboration. Whilst health visitors, for example, said they felt greater collaboration would be beneficial, they also felt, at the same time, that it would be

difficult to achieve. District nurses, on the other hand, were less sceptical:

> I think these [relationships] are getting better every day because people are working together especially now. Before, the health visitor and the district nurse didn't know what kind of job they were doing and now, as I say, one's backing out and letting the other one do it. We're getting to know each other. That's getting better. (88AB)

Like the medical respondents, and in contrast to health visitors, district nurses did not strongly favour greater emphasis being placed on prevention and health promotion:

> I think generally through the media and through reading, the patients should be aware of a lot of precautions - I know a lot of people aren't aware of them. But no matter what was wrong with them, even if we did go in to educate everybody in the whole area, I don't think that would make much difference either. I mean, you could educate for months on end and still find that what you've advised people to do doesn't always sink in. (29DW)

While health visitors stressed the need for more health education, district nurses tended to favour technical strategies such as more screening:

> I think screening is certainly terrific. But again it needs a lot of money and a lot of time as well but if the doctors are enthusiastic then, for instance I'm not involved in screening in this practice but I'd be quite prepared to help

should they want to do it. I think that is a good idea. (17JB).

Asked directly whether better use could be made of existing resources, district nurses were much more hesitant than health visitors as to whether this was possible. Less than half felt it was, and the sort of savings that could be made ranged over a number of possibilities - cutting administrative costs, saving on use of equipment and so on. It is worth noting, however, that when asked at another stage in the interviews about withdrawing resources from one sector to give to another, several district nurses suggested making better use of existing resources within sectors rather than reallocating across sector boundaries - and the most common suggestion was to cut down on administration:

> I think if they cut out a tier of administrators, they could devote money to it [the dependency groups].... I feel that the health service functioned reasonably well before the reorganisation of the health service and I don't feel it's been improved sufficiently to justify the money that's spent on the tiers of administration. (35JK)

c) Community care

District nurses follow broadly the pattern demonstrated by other NHS respondents (GPs, consultants and health visitors) in their definitions of community care. Half of them saw it as meaning any form of care given outside hospitals but a third saw it as care provided at home. This distribution reflects perhaps the

two components in their role - they are part of the NHS/local authority divide, identifying with their own agency's broad orientation, but they provide, *par excellence*, domiciliary care.

And following that involvement with the provision of domiciliary care, when asked what services they would most like to see improved, almost half stressed the need for more domiciliary services:

> I'd say the geriatric supervisory service. There could be an awful lot more of these kind of people and I think it would be very valuable.....talking about the geriatric visitors, nurses, I think it is a very valuable service. I'm very sorry it has been phased out. Again, it's getting back to the preventive thing then, because if a patient is kept an eye on then you could forestall a hospital admission. (15JK)

But significantly well over half argued at the same time that *institutional* care ought to be improved and increased. Thus the category of staff most directly concerned with the day to day provision of care 'at home' also saw the need for institutional care:

> I think we should probably have more geriatric units but - I don't know if the term geriatric unit is a very good one - medical wards, a lot of acute medical wards have got half a ward full of people that don't really need acute medical care any longer. We need to expand greatly in some way because there is a need for long-term care for a lot more people
>
> (87AB)

and

> You know if we could get money to build more, you know, residences for caring for the elderly, fill the beds (05JBE)

Home care was not necessarily seen as the only form of appropriate care despite their view in the moral context that family and 'own home' care was superior.

d) Working life

District nurses along with health visitors were almost unanimous in their sense of working under heavy constraints. They saw themselves as over-worked and harassed:

> I think with shortage of staff, I've not got the time to go down and maybe have a word with them. If I had more time in the afternoon I could go down there [the social work department] and have a word with them about a patient. And I think this is the best thing, sort of one to one contacts - an awful lot better than leaving messages over the phone, but again through pressure of work we just haven't the time to do this. (15JB)

The work was stressful and they were dogged by shortages of resources, manifested in the demands made on their working time:

> Materials you can be very short of at times. Mostly our biggest problem is staff shortages. If you're not actually short yourself, somebody else will be and you have to help them, consequently making you more busy. (15JK)

In terms of working relationships, it is interesting to note that no professional group reported having difficulties in working with district nurses; they are not regarded as a 'difficult' group. However, district nurses themselves reported occasional difficulties which they themselves had with other groups - chiefly social workers and GPs:

> I think some GPs will tend to, what I say, throw all the dregs of the day at you. An old lady who perhaps could do with a check up now and again - you could end up with a list as long as your arm of old ladies like that or sometimes where there are difficulties in looking after an old lady in bed, incontinent .....if the GP is not very helpful at, say, getting a geriatrician out... then you're left with it to do. (15JK)

In the case of social work, they reported greater problems with social work *as* an agency rather than with individual social workers (although these did exist):

> In my last practice, I did try to contact them [the social work department] and it was a terrible problem because they were at their office at different hours from when we were in our office and then when you did get hold of one, that was fine, they were very helpful. but when you tried to re-contact you just couldn't get the same one. I really don't know much about them. (88AB)

And although they noted difficulties in working with GPs, there were more reports of *good* relations with GPs than of poor ones.

District nurses were also much more ready to talk positively about other professions than most other groups. Some appeared to be prepared to accept the possibility of sharing tasks and redefining traditional inter-professional boundaries. And yet, at the same time, one of the reasons why they seemed to experience relatively few inter-professional boundaries was the clearly defined and separate nature of their tasks. In that respect it would be somewhat difficult to share roles and tasks with other professions (such as health visiting and social work).

WARD SISTERS

Eighteen ward sisters (or charge nurses, if male) were interviewed, some in psychiatric hospitals, others in general hospitals.

a) The moral dimension

Ward sisters, of all the respondents, are located exclusively within the hospital setting; the same is true to almost the same extent for consultants but several of those have some contact outside in the community through clinic sessions or domiciliary visits for assessment. Ward sisters' views about community care are not grounded in any very direct experience of what goes on in the community, although they may, of course, have personal experience of it aside from their nursing roles.

Apart from their medical colleagues, the GPs, they are the group which least believes in state responsibility for the care of dependent people. Like GPs and district nurses they favoured family responsibility, together with professional backup:

> I think it's the family's responsibility to a great degree. I think too much has been handed over to the state, both in old people and young people. I think people have got to learn again to take their own responsibilities. I mean there are some cases you can't - husbands won't have mothers

staying, you know. There are some impossible cases, people you couldn't possibly look after but I think they should take more responsibility. (18DW)

They tended to take a 'middle of the road' view of the question of public expectations of the services. Just over half believed that the public does expect too much:

It's difficult, but there are some people who expect just everything to fall on their plate in front of them. (02JBE)

But this was less than district nurses and consultants and substantially less than health visitors and GPs. While half also felt that in practice the public does not take responsibility, another two fifths felt unable to pass definite comment:

I think it's very difficult, I think every case has its own merits really; there's some people who wouldn't and some folk who just wouldn't give up looking after their relatives. (77AB)

This may have something to do with ward sisters' lack of direct knowledge of what actually happens 'in the community'.

Insofar as the voluntary sector is concerned, a solid majority of ward sisters supported its involvement in the provision of care although with less enthusiasm than, for example, health visitors who unanimously supported it. However, like all other NHS groups, they saw voluntary effort as supplementary to professional support:

In a limited way - yes, they can be quite helpful....you don't expect a volunteer to come in and change incontinent

patients. There's lots of legal things they can't do. I mean, if a patient was to fall in the bath and things. They come in and do things like help and assist in social evenings or go round and give them a cup of tea, or even just sit with the patients, just befriending them. (76AB)

Indeed, the few reservations which they expressed about it were couched in terms of its possible encroachment into professional territory. This is a theme which recurs constantly amongst all groups.

b) The priority policies

Like consultants and GPs, the ward sisters supported the priorities but not without a fair degree of equivocation. But they, more than any other group of NHS respondents, registered disagreement with them:

No. I think everybody should have the same you know. Because more and more of the - there's younger people coming into hospital that are not going to be high dependency.... I feel that they are more entitled to the bed at the hospital than a high dependency patient. Well I mean we had one chap, a 29 year old chap with a heart attack you know. And there's more of them going into intensive care and that's the ones we're losing.... you know, I feel that these people should be in as well. (12JB)

and

I don't honestly think they should have priority but there again I don't think they should be a minority in any way (30DW)

Like others of their NHS colleagues, many of them (one third) said that no sectors should lose resources at the expense of the dependency groups - and more than that were not prepared to make a choice at all:

Well I think to a certain extent yes [I agree with the priorities]....but [it's] very difficult to say really. I think it would depend on the situation. I wouldn't like to commit myself yes for definite. It would depend on what was going to be pushed aside for it. (15JKE)

Few were prepared to say that the acute sector should lose.

In spite of their somewhat reluctant support for the priority policies, they were prepared to single out one particular group for priority - and that group, uniquely, was the mentally handicapped. One respondent (82AB) talked about care for the mentally handicapped as being 'light years behind even the old people' ((Had they chosen the mentally ill, it could have been accounted for by the number of psychiatric nurse involved in the sample, but none of the respondents was concerned with nursing the mentally handicapped). No other group, in the whole sample, selected the mentally handicapped for priority. It might be that ward sisters in this choice were expressing views more close to those of the public than those of professionally involved staff; they were not influenced by their own work experience.

They also expressed an unquestioning belief that better use could be made of existing resources with little recognition of the complexity of problems involved. Areas for improvement spread across the range - equipment could be better looked after and wasted less, services could be more sensibly organised and administration could be cut back:

> It's not something I've really thought all that much about. There's always room for improvement in all situations ... there's always wastage of manpower as well as resources, so I guess that there has to be some way of improving the situation inasmuch as we don't have money coming in but to use better and better ways of what we have already got.
>
> (79AB)

When asked about whether resources within the chronic sector could be reallocated, less than half (rather similar to district nurses) argued in favour and by this most meant that they favoured greater collaboration between agencies and between professionals. One ward sister argued, unusually, in favour of diverting resources from institutions to the community

> Well at the moment I think it [should be] the community, I think they're needing home helps and meals on wheels. I think that's desperate. All very well improving hospital care and what not. Hospitals are very modernised, they've got all their modern equipment as it is. I think hospitals at the moment are very well equipped. (81AB)

Nevertheless, a quarter of the ward sisters were sceptical about what could be achieved - especially in terms of restructuring the services on a collaborative basis:

> Oh it would be nice if everybody could be under one 'roof' but I suppose that would take months of reorganisation and would cost an absolute fortune and there would be so many rows about it that it would probably be a long time before it ever happened - if it ever does. (78AB)

Only a quarter felt positively that more resources should be devoted to preventive measures and in this they resembled their medical colleagues (consultants and GPs):

> That is what the health visitors should be doing but they seem to have such a large case load.... they [the clients] say they see the health visitor maybe once a year or once every six months. Now a lot can happen in that six months or a year. I think if they were educating more, seeing that they were eating the right diet and - aware of all the various facilities they could use, I think a lot more could be prevented. (76AB)

A further two thirds however expressed mild support (substantially more, in this case, than their medical colleagues);

> There always will be some people as I said already that appreciate things that are done and will try and cooperate. And they ....then you get the other half that don't give a damn anyway. So then again still going to be educating

about half of the people and half of the people aren't going to care. Very frustrating I would imagine. (22DW)

Almost all of those in favour saw this as meaning more emphasis on health education measures, rather than the technical or interventionist strategies favoured by some others.

c) Community care

Ward sisters, of all the NHS respondents, felt most strongly that community care meant care in one's own home:

I think community care is being able to keep them in their own home, to make them as comfortable and happy and to vary their life as much as possible in their own home. (15JKE)

Almost half felt this, with a third of them seeing community care as meaning any form of care outside hospital:

I think community care is, also involves hostels, half-way houses and old folks homes. I think that can be counted as the community. (07JBE)

This split represents two differing approaches to definition. In the first instance those defining the term as being about 'own home' care, saw it as something outside their professional competence and thus were probably employing a lay approach to the term; in the second they were seeing it in terms of their own professional positions - they were employed in hospitals, they did not provide community care, therefore community care was anything they did not provide (that is, anything outside hospital).

In contrast to the district nurses, ward sisters felt less strongly that more should be done to improve institutional provision than domiciliary or community-based services (although they were themselves based within institutions). A third wanted to see better domiciliary services with another third feeling that local authorities ought to provide better services in the community. A number of respondents (more than in other groups) suggested other improvements too - such as better transport for patients, financial help for relatives and better advice for users of the services in general. Given that the respondents were all hospital-based, this variety of responses is perhaps more imaginative than might have been expected. It may be that their thoughts were not based on working experience but rather on views derived from their 'personal' or 'lay' experience.

d) Working life

Ward sisters complained less than any other group of staff about the constraints they had to work under, but when they did it was predominantly about their workload - just as in the case of other front-line nurses (health visitors and district nurses):

> The pressures are not enough hours of the day. And the thought of reducing working hours, you know making our [working] day shorter, that would be my biggest problem.
>
> (02JBE)

The other constraint which featured to any extent was that of the difficulties created by industrial action (field work was

conducted at a time when industrial action was being taken by ancillary staff in hospitals, so that hospital wards were experiencing difficulties with services like laundry).

Ward sisters' reports about working relationships with other professionals reflected their relatively narrow horizons. They reported a few difficulties with consultants and the problems which they identified were predominantly those of consultants' attitudes of superiority towards them:

> They tend to listen - well we're with them 24 hours a day, I think we should be listened to. We get the odd one that seems to say 'Oh I'm the consultant'. But you'll find most of them nowadays they just sort of take your advice. (76AB)

After consultants, their problems lay with other nurses and with their nurse managers. The issues which concerned them were mostly to do with line management and organisational problems:

> With line management, right. Well nursing officers - I have - well - bit of a personality clash. But actually I came [to replace her]. This was her ward before she took promotion and she's never really let go. And I'm a very strong willed person. (12JB)

But apart from these instances of intra-professional problems, there were few others which the ward sisters reported. They tended to have little contact with other groups of staff; their world is confined mostly to the ward and to the hospital. But usually there were teams of social workers based in those

hospitals and it is worth noting that the ward sisters did not report difficulties with them - although they were less positive about social work as an agency. This was often to do with shortages of resources or organisational hiccups to do with discharge procedures:

> Oh yes, you hear then [when patients are to be discharged] the home helps complain because we wern't giving them enough time, but that's ridiculous. You can't give them, we were giving them a week or something like that. What more do they want. (81AB)

But in general problems with social workers as individuals were not widespread. In this they were unusual; most NHS groups tended to cite difficulties with social workers.

NHS MANAGERS

Fifty four NHS managers were interviewed. These included the most senior (such as CAMOs, Health Board Secretaries and Treasurers) at area level, along with district level officersas well as middle managers down to first level managers (in both cases involving both nursing and administration). I decided to group all these respondents together in spite of the diversity of their professional backgrounds because their chief function *at the time of interview* was a managerial one - although, of course, related to the particular professional groups for which they were responsible. It was the managerial perspective that I was anxious to investigate.

a) The moral dimension

When taken as a whole, NHS managers divided evenly between those who felt that it is predominantly a state responsibility and those who felt that it was largely a family responsibility to care. When examined according to seniority, the most senior managers believed much more strongly than others in state responsibility:

> I think it's an absolute state responsibility. I think it's totally unjust in all senses of the word to expect a family to look after dependent relatives at the cost of - we only get one life, you know, we only get one crack of this

particular cherry. And I think one of the tragedies that strikes me most is to see perhaps girls devote their lives to looking after an ailing parent, and at the end of the day, what do they have? We only get one shot.

(Health Board Treasurer 57AB)

This was repeated in their attitudes towards the public's willingness to take responsibility. Whilst almost half of all managers believed the public takes responsibility and less than one fifth believed that they do not, almost three quarters of the most senior managers believed that they do with not one of them thinking the contrary (the remainder said they cannot generalise):

I think that people are prepared, most people are prepared to take quite a considerable responsibility. I certainly don't accept the view that nowadays people don't care about their parents and this kind of thing ..... and the same is true of the mentally handicapped. I keep being astonished at that, the parents sacrifice their lives for the mentally handicapped kid and there were days gone by when they were shoved into an institution. They're hardly taking anyone in now. (Health Board Secretary 04GL)

But it should also be noted that managers taken *as a whole* were generally more sympathetic to the public than other NHS respondents on this question (apart, perhaps, for consultants).

Opinions about public expectations of the services were similar across the range of NHS managers. Although almost half of all

managers felt the public does expect too much, this was less than other NHS respondents - and of the other responses to this question, roughly a quarter of all respondents felt that they do not expect too much:

> I feel that in our district often they have too low expectations quite honestly..... I think they should be a lot more vocal about getting decent facilities.
>
> (District Medical Officer 05GL).

Managers' views are not conditioned by direct face-to-face experience of the delivery of care and the consequent frequent contact with the realities of care at home and in the community. Nevertheless they are conditioned by the very real experience of having to make choices about the allocation of resources (in terms of the allocation of staff time at lower levels and in terms of overall budgetary decisions at higher levels); their duty (variable according to seniority) is to address the very issues represented in this study. This perhaps has some bearing on their responses; there is little of the moralistic judgement of the public which some of the other respondents display (especially, for example, the GPs). They see their responsibility as providing state sponsored services to the public and they support that view of their responsibility in their views on the state/family issues:

> We should - the community must do that for them [provide support services]....we have a very competitive and demanding society and more and more people are, you know, on this

lower threshold, because of increased pressures - more and more people are obviously going into this category of .. [needing state services and support].... it's not so much a duty as for society's self-preservation.

(District Medical Officer 50AB).

Their views on the voluntary sector are interesting in this respect. Managers were relatively lukewarm in their support of voluntary sector involvement. Only a quarter supported it strongly (and no senior managers did) - much lower than any other group (except for social work managers as will be seen later). Half of all NHS managers gave only equivocal support to the voluntary sector and almost a quarter were in fact positively dubious about it (much more so than in any other category). One of the district medical officers quoted above said:

I'm sorry, but I've never - there are some splendid ladies and gentlemen mixed up in those [voluntary organisations] but ....I don't think you can build a service on that kind of thing. I may be wrong. I would be delighted to be proved wrong. But from my observations, no. (50AB)

This fits with their view on the role of the state but it also in part is an expression of their frustration with voluntary effort that interferes and disrupts their financial forward planning. Fund raising by the public, especially for expensive high-tech equipment (a popular form of fund raising) has running cost implications which distorts health boards' revenue expenditure

plans in unforeseen (and costly) ways. Thus the involvement of the voluntary sector is often regarded as a mixed blessing:

> How can you be annoyed at the general public wanting to help in a good cause..... I think it's very difficult to discourage them, but again the thing is too haphazard and they jump on particular bandwagons really, in the order of things, giving a priority to things that perhaps are not the Board's first priority. But you've got to measure that against the fact that if they didn't collect it for that particular cause, they wouldn't collect it at all - and as Treasurer, being a typical hard-bitten accountant, I find it very difficult to look a gift horse in the mouth.
>
> (Health Board Treasurer 57AB)

b) The priority policies

The priority policies are another interesting case as far as NHS managers are concerned. Managers, senior managers in particular, are those charged with the duty of implementing policy (and, some would argue, formulating policy at the local level). It is their chief task, but at the same time they are the staff most well-placed to be aware of the difficulties involved in implementation. Policy-makers (at national level) might expect wholesale endorsement of their policies by those employed to implement them but they may fail to recognise the pressures of competing demands placed on managers at senior levels.

It is therefore not surprising that only a third of all NHS managers positively supported the priority policies - with another third giving equivocal support. And it is the most senior managers who were the most equivocal. A Chief Area Nursing Officer, for example, expressed it in this way:

> No, I wouldn't disagree with the philosophy of SHAPE [the priorities document]... it's the implementation of it that I'll argue with.....I think the difficulty is in transferring the resources from the acute services to the other, because the acute services are also important services and it's very difficult to say we'll stop all renal dialysis in order to boost up Lennox Castle [mental handicap hospital] or something like this. How does one make this choice? And it's very difficult. (01GL)

Although over one third of managers as a whole said that it must be the acute sector that should lose resources, double that proportion of senior managers pointed to the acute sector. Their equivocation in terms of their support for the policies as a whole was not matched by their firm realisation that resources could only come from the acute sector if they were to come from anywhere. Just over a quarter of all managers, but mostly middle managers, however, said that no sector should lose resources in order to implement the priority policies. A divisional nursing officer was worried that groups which did not deserve to lose resources might nevertheless end up losing as a result of the policies and felt this would be wrong:

I think the groups that might lose out are people who are requiring, the hernias, the bread and butter surgery, that sort of thing, and these are the sort of people who are really the workforce of the country. And I am a bit concerned that these people might lose out....I think I'm getting myself into hot water here but... I would find it very difficult to answer because in my view they are all priority groups really. (17JK).

Managers saw the elderly as being of prime concern. While just over half did not single any one group out for preference, many of them named the elderly as *one* of the chief priorities and of the remaining half nearly all singled out the elderly or the mentally infirm elderly as being the group most in need of resources. This may well be related to their perception of the relative levels of numbers - the elderly forming the largest and growing category. However, the same argument does not hold good for the mentally ill - also a large category - but low down on managers' list of priorities:

If you are pinning me down on it, I would have particular sympathy for the elderly because they are the most vulnerable. I know of mental defectives who are going about, they are strong, enjoy their pint, they are not particularly deprived in any way. Even the mentally ill are often quite happy, although they are living in a different world from me.....whereas the really old are vulnerable.

(District Medical Officer 03EL)

More managers (over half) than any other NHS group believed that there could be a reallocation of existing resources within the chronic sector (although the rest were not prepared to pass an opinion or said that it was too difficult to respond to). Of those who believed in such a reallocation, a number suggestd transferring resources *from* the NHS to the local authority, to provide care for, for example, the elderly:

> It might be a better way than implementing SHAPE. It might be to deduct some money from the health service and give it to local government.... they would do it different, whether they would do it better, I don't know...for instance, if social work wished to take over Lennox Castle, that would be all right...it would change slowly to a more social type model from a medical type model and that would be perfectly appropriate, I think.
>
> (Chief Administrative Medical Officer 03GL)

Another smaller number also talked about transferring resources from institutions to the community:

> Probably for community care, but I don't think for institutional care because the need's very different..... no, I don't think in institutions probably in the community.
>
> (Senior Nursing Officer 23JK)

In both cases, it by no means approached a majority, but there were markedly more suggestions of this kind by managers than by any other groups. This is perhaps because managers are likely to be more conversant with current policy debates about the

structural and budgetary relationships between agencies than other professional groups.

Other suggestions which managers opted for related to improved collaboration between agencies. Whilst a number of them talked about improved inter-*professional* collaboration (as did many other groups), they stress inter-agency collaboration more so than any other group. And in addition to this, a number of them mentioned the possibility of amalgamating certain aspects of care provision usually provided by the NHS on the one hand and local authorities on the other:

> I think have the local health, the community health and the social services and social work departments working closer together - and probably paid for out of the one budget, whether it be local or a national budget.
>
> (Sector Administrator 11JB)

But in spite of favouring improved collaboration or opting for amalgamation, many of them (over half) expressed scepticism (and only a tiny number optimism) about the likelihood of improving collaborative relationships:

> I think an awful lot of these things come back to finance basically. But I think before that, there's the problem of the structure before you get to - even just to get the two lots to agree, is a problem, never mind trying to get them to allocate money on the principle - just to agree in

principle is difficult because you've got two different structures, two different lots of people.

(Sector Administrator 01JK)

In response to questions about prevention, managers (just over half) were relatively positive about the suggestion that more resources should be diverted towards preventive policies - more so than any other category except health visitors. Most of them saw this as meaning greater investment in health educational activities:

I think a lot more is being done to prevent, I think possibly a lot more could be done ... well, education again. And it's no good trying to start educating a 50 year old man he shouldn't be smoking. It all needs to be done at a much, much earlier age. (Senior nursing officer 19JK)

Senior managers were more cautious in their support, almost half of them expressing only mild support and almost a third being sceptical about the utility of such a policy in the present climate of resource shortage:

You know, apart from immunisation against infectious diseases, I'm not sure what you prevent or how you prevent it....there is so little generally proved preventive material in it, that I don't really know if I honestly can say putting money into these things is going to produce a dividend.... I mean it's not a good investment in that I'm not sure what we put our money into honestly as prevention

and we try to support the Health Education Unit and so on - but is our health education working?

(Chief Administrative Medical Officer 56AB)

When questioned about whether or not they felt better use could be made of existing resources, a lot fewer managers than all other categories (except district nurses) agreed. Under two thirds of them believed it was possible and where they did it was largely, they felt, a question of rationalising existing services - reorganising them more productively:

I think people are trying harder now looking at resources and being more careful about where they put them because they're scarce. I think maybe at one time, maybe people weren't looking as carefully at things as they should. But I think it's all these groups of people wanting different things, you see, and they're all saying - nobody co-ordinating - and they're saying, well we want this facility and somebody else is wanting that facility and there doesn't seem to be anybody sitting down and weighing them up and saying which facility is for where or more desirable.

(Senior nursing officer 75AB)

Very few, not surprisingly, were convinced that cuts could be made in administration or in equipment savings (those were areas for which they, of course, might be directly responsible):

I don't think so, but then of course I think that, because I don't think that the administrative costs of the health service is high - I think it's too low, not too high....

but I'm a biased observer - I'm one [an administrator] myself!

(Chief administrative medical officer 03GL)

c) Community care

Managers follow the broad pattern of NHS responses: that community care is essentially that which is provided outside hospital (the non-NHS option):

Once they're out of hospital, they're in the community... normally.... they're in hostels or they're in an old person's home. (Divisional nursing officer 34JK)

and

I think it really encompasses everything which is outside hospital (District nursing officer 02EL)

Almost half took this view with another half spread evenly between the 'own-home' and 'non-institution (excluding old people's homes as well as hospitals)' options.

Managers as a whole show a much more varied and even spread of responses than other categories in relation to questions about what they saw as necessary improvements or extensions of community-based services. Their suggestions covered the whole range of possibilities:- they wanted to see a whole range of domiciliary and community services to be provided by both the NHS and local authorities - but in addition they wanted more hospital and residential facilities to be provided by both agencies. This

breadth of view may be closely related to the role managers play in the planning and organising of services. While practitioners may have a clear view of needs in relation to the parts of the services with which they are involved, it is often only managers - and especially senior managers - who have the overview and who are expected to think and see things in a strategic way:

> My own view is that they [support-financed projects] were set up as a matter of expediency at a time when there were problems with local authority expenditure as a way of diverting some health board cash into social services...So I would think the method of funding could perhaps be looked at. In other words if something is a joint thing then is it not going to continue as a joint venture through to the end rather than this shifting of resources [tapering off] ....Perhaps day centres for dependency groups. Thinking in terms of young chronic sick and again problem children with physical and mental handicap....chiropody services....I would think hostel provision.
>
> (Senior administrative assistant 17JKE)

d) Working life

Along with all other respondents, a solid majority of managers said they have to work under constraints. In contrast to the front-line nurses, however, they did not cite workload as the

chief issue. Overwhelmingly, and just like consultants and GPs, they cited shortage of resources and cuts in resources as being their chief problem:

> It's resources...also we are going to get with the difficulties of recruitment of some specialist staff, recruiting psychiatric charge nurses, for example.
>
> (District Nursing Officer 02EL)

Following this came what they saw as difficulties associated with the nature of the work they had to do - largely to do with the difficulty of making plans and decisions in an environment which was full of so many competing demands and interests:

> I think the current organisation [uncertainty] and I think problems of not knowing about what your financial position is would be the two that spring to mind.
>
> (Chief area nursing officer)

and

> I think that lack of resources is much easier to cope with - if you haven't got it, you haven't got it, and it then generates the difficult task to try to re-direct resources but that is a task which I think any administrator would happily address himself to with some degree of enthusiasm in the knowledge that if you can achieve it you are benefiting the service as a whole.... but no, far more difficult is sorting out the morass of the bureaucracy.... being a bureaucrat, an administrator in the service, your main role is soaking up the aggro, and it's amazing the amount of aggro that is generated in this kind of stratosphere in the service

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> which is above the good patient care work that is going on, but there's all this semi-administrative activity is going on to no purpose and it's hard to see it ever being progressed because once having established the structure and the consultative machinery, and the complexities of national instructions that come down, and the emotive activity and bureaucratic effort that goes into it, and, as I say, it's the one thing that is regarded as totally expendable in the service is administrative effort. But it gets through to people [the administrators] and there's a lot of disenchantment. (Health Board Secretary 55AB)

The field-work for the study was conducted before the introduction of general management into the Scottish health service. Managers at this time worked to the system of consensus decision-making; in terms of strategic decisions, the management group as a whole at each level had to be in common agreement before a decision could be made. Many respondents saw this as problematic - in terms of delay and ineffectiveness - but at the same time very few respondents warmed to the idea of a chief executive (or general manager) being brought in to make final over-riding decisions - although one of the respondents was enthusiastic (although unbelieving that it would ever happen):

> I think the health service will only be really efficiently effective if it was a managed medical service - with a director-general up top and a definite managerial hierarchy right down the line.....I say that's one way it

would work effectively but it's quite an impractical suggestion. The way the health service has developed over the years, we couldn't do that. We'd land in the most awful trouble. (Chief administrative medical officer 56AB)

In terms of difficulties in working relationships with other professional groups, managers reported most difficulties with consultants. One respondent expressed her views strongly:

I suppose I'm probably known locally as being a doctor hater - that's not strictly true. I object very strongly to members of the medical profession who feel that the health service is run by them for them.....one saw it...even last week where a group which used to be a commissioning team and has now got a remit from the Board.... looking at the major servicing here - but you see the chairman of that group is a doctor, the people that they want to see individually as to what they think should be the requirements of the locality are individual consultants.

(District nursing officer 02EL)

This reflects difficulties they found in the decision-making process. The claims by consultants to 'clinical autonomy' created major difficulties for managers wanting to make decisions for the service as a whole. As long as clinicians were able to remain outside the decision-making control of managers, managers would always be likely to perceive their relationships with them as difficult:

I think they [the Board] have got very little control over

them once you appoint them. The real control is whether or not you appoint them, so if the Board wishes to control the medical profession, that's how it does it....[but] I think that the easy way is to replace people as they retire or they leave and that's what most Boards do. The move to appointing different consultants in different specialties is a very slow process and you've got to face the absolute reality of the situation that not many doctors are attracted to the cinderella services.

(Health Board treasurer \ 57AB)

After difficulties with consultants, managers reported difficulties with other health board officials. These were mostly to do with problems of the management hierarchy. There were many examples of difficulties reported between district officials and area officials: either that districts were not given enough freedom to act for themselves, or that the area management group was too far removed and uninterested in the local problems of the district:

I think there could be a more sensible division of work between the Area and District. I mean if there was a philosophy of management in the Area that they were to be concerned in the main with policy-making and planning services, and if they spent the greater part of their time trying to draw a canvas with all the various services on where they were going and left us to manage the thing. I

think too often instead of complementing work by District they are trying to compete with us.

(District Administrator 01EL)

The third group of professionals with whom problems were reported was that of the GPs. GPs tended to see health board managers as being there simply to cause difficulties for their attached staff (district nurses and/or health visitors) or to restrict access to certain services:

GPs - if you get attached, really attached, working from the surgery, then it's a reasonably happy situation. I think the GP in the main feels paternalistic towards them all and they're his health visitors and his district nurses and I don't mind at all. I feel I must accept that, in theory anyway, for the benefit of the patient 'cause if I, it's nice that I remain the big bad wolf because if there's something that the district nurse or the health visitor really feels is wrong about something the doctor's asking her to do...she can say, oh well my boss says, whereas if she had to say it herself it would cause ill feeling. I accept that, it irks me occasionally, but I accept it.... but there are other attachments, the GP really doesn't understand what they, what their role is or he thinks that they're his servants... they think the district nurse and the health visitor do the things they haven't time to do, and if she's not prepared to do some of the things that they haven't

time to do, they criticise her and say she's not much use.

(Divisional nursing officer 69AB)

Health board managers resented these attitudes. They felt that GPs did not have any understanding of or any inclination to understand the workings of the health board and its staff.

While managers did not mention individual social workers as being difficult as often as they found the first three categories mentioned above, they reported overwhelmingly that they found problems in their relationships with social work as an agency. This was at all levels, from senior managers trying to establish relationships with senior management in social work departments down to middle managers trying to understand the workings of the social work team based within the hospital:

> I think that the difficulties are that they are accountable to different masters and therefore liaison between two separate institutions, if you can call it that, has got its inherited kind of problems...and it's easier to, well it becomes slow, it's easy to avoid decisions and the question of funding becomes a central issue where there's a grey area, where something isn't clearly delineated as social as opposed to health... (Chief area nursing officer 59AB)

and from an officer lower down the structure:

> I am not impressed with social workers, end of story, I'm afraid....I'm not impressed with the ones I come in contact with here in the hospital and that means the ones in the geriatric area...I suppose it's difficult because, for me

really, I trained before we had all these disciplines and quite honestly, if a patient was going home, it was the nurses that did it and I just do wonder is it necessary for another lot of people to get involved.... I do think that perhaps we have gone overboard and looking at it coldly, I think a lot of money is wasted.

(Senior nursing officer 19JK).

For senior managers complaints about the social work department paralleled the way in which they often found themselves up against the medical establishment.

Managers then appeared to be harrassed and unable to fully control the environment for which they were in many aspects responsible. They were well aware of the complexity of the issues which confronted them; they were amongst the most broadminded of all respondents. But they were also only too aware of just how difficult it was to make decisions and achieve change.

CHAPTER FIVE

PROFESSIONAL PROFILES: SOCIAL WORK RESPONDENTS

SOCIAL WORK MANAGERS

Thirty seven social work managers were interviewed; they ranged from directors of social work down through their most senior managers to middle managers at area or district levels and included home help organisers, residential officers-in-charge of old people's homes and hostels..

a) The moral dimension

Social work managers as a whole clustered around the middle of the continuum, state - family; very few managers favoured the 'primarily family' *or* the 'primarily state' options:

> Although I'm saying relatives shouldn't be expected to cope with fantastic problems, on the other hand, I'm not saying that the state take all responsibility away from them. (Social work middle manager 35AB)

and

> I think it's both - I think the family has to cope as much as it can, but there's a point beyond which it can't, and it can't...let me clarify what I said

earlier on: ...there will always be a need be a need for social workers, because they do have the training and they do have the skills, knowledge, awareness.

(Area officer 38JK)

Most other professional groupings were more widely spread in their responses with proportions of a quarter or on occasion (the GPs) almost one half registering support for the 'primarily family' option. But social work managers' reluctance to support the 'primarily family' option to any great extent seems to reflect (as will be seen later) a wider difference between social work respondents on the one hand and health service respondents on the other.

Social work managers had a much more positive view of the public's willingness to take responsibility than did most health service respondents - except for health service managers, where there is some similarity in views. Relatively few managers of both sorts believed that people do *not* take responsibility (less than a fifth), but more social work managers than those in the health service felt positively that they *do* (over two thirds compared to just under one half). There is little difference between managers at different levels in this respect. A depute director of social work, for example said:

Answering generally, a lot of families take a heck of a lot of responsibility. I think it's - obviously, one wants families to take as much responsibility as they can. I think what you've got to do is to try and build

a service that will help families when they need support.

(27AB)

And a district social work officer (a middle manager) spoke positively of the public:

> It is rubbish to say that [the professional services] take prime responsibility. Families do....so to think that families are not looking after their own people is just a nonsense. (09JB)

Like all groups, a substantial number (just under half) of social work managers believed that public expectations of the services are too high (but mostly not judgementally):

> Yes, they expect the welfare state to deal with everything. After all they've been brought up in the welfare state and the middle-aged adults now have been brought up in a welfare state and expect the welfare state to do everything. After all they are paying their taxes very highly and the older pre-welfare state generation would say, use the welfare state more sensibly.

(Principal hospital social worker 29JK)

But nevertheless all health service groups, excepting, again, NHS managers, recorded greater numbers believing this to be so than the social work managers. Social work managers and NHS managers showed a very similar pattern of responses - almost half believing the public expects too much but just over a quarter believing firmly that they do not.

Social work managers then were much less hardhearted in their views of the public than other respondents (apart from NHS managers and, we shall see, their other social work colleagues). This may be linked to their views about the relative roles of state and family. Although they did not adopt the view that it is primarily the state's view to take on responsibility for care, they did firmly believe in the partnership of state and family.

In relation to the role of the voluntary sector, almost three quarters of them gave conditional support to its involvement with the remainder being firmly in support. In contrast to most health service respondents, social work managers saw voluntary sector activity as providing the opportunity for innovative schemes to be tested out:

> I feel about voluntary organisations, that they are at their most effective when they are doing the traditional thing - of highlighting and throwing up fresh need, if you like. I think the second thing that they are very good at, is tackling things that local authorities back off of, for a whole lot of reasons - either because they're scared or [whatever].
>
> (Depute director of social work 27AB)

Again this pattern of support is not dissimilar from NHS managers, except that none of them was dubious about the role of voluntary effort. For NHS managers this was a real issue (and has become so increasingly in subsequent years); social work managers however do

not generally have to accomodate rushes of unplanned public generosity in the same way.

Like many health service respondents, almost half the social work managers were careful to stress that voluntary sector involvement should be supplementary to professional effort:

> I feel that the department has a responsibility to offer services. What we would be hoping in the voluntary sector is complement what we are doing in that they could back us up in provision or, for example, if we take the elderly, maybe a visiting service or just simply going and befriending an old person. (Specialist advisor - elderly, mentally ill & handicapped 13GL)

b) The priority policies

As many social work managers expressed the same sort of approval and the same sort of equivocation about the priority policies as NHS managers. But at the same time, about a third of them felt unable or were not prepared to pass a definitive view:

> I think there's an area, there would be areas of disagreement. If the health board say for example that the elderly have been targeted who's going to argue with that, but when you begin to do the trageting, you narrow that targeting down and once you narrow it down, then you get indifference of opinion.
>
> (Principal officer - residential and day care 14GL)

In addition, there was very little outright *dis*approval - whereas a number of NHS managers expressed such disapproval - and it was suggested that the reason for their disapproval or equivocation might be related to their knowledge of the complexity of the issues. It is perhaps important to note here that the main thrust of the policies as expressed in the policy documents was aimed at the health services rather than the personal social services. The immediacy of the issues might therefore be perceived differently by NHS respondents on the one hand and social work respondents on the other. One respondent, for example, was clear that other social work client groups should take precedence:

> I wouldn't say they [the dependency groups] would be my my particular choice as priorities... because I would say that the poverty-stricken young families are more of a priority. And that might sound cruel but it's not to me, you know. (Area officer 16DW)

And a director of social work felt that the health service had different problems from social work in facing up to the implications of the priority policies:

> I think we don't have the problem about the differential glamour between acute medicine and chronic illness in social work because by and large we're preoccupied with the chronic problems in any case, so I think that gives us one enormous advantage when it comes to the question of prioritising. (10GL)

The matter of immediate relevance arises again when responses to questions about which sectors should lose resources are examined. Whilst a quarter of social work managers saw the policies in health service terms and argued that resources should be taken from the acute services, another quarter saw the issue more broadly and felt that there were non-health service areas which should give up resources - such as defence or education. And a very small number responded in an even more expansive way, by suggesting that the whole of society should be re-ordered:

> The trouble is we have a society which is built on profit .....[we need] God knows, start re-thinking about society. Really got to start thinking about society..... by scrapping our present society. You're asking me for a solution, I'm giving you the solution as far as I see it. Scrap the present society and its construction towards profit. And I can't answer in any other way. (Area officer 19DW)

Very few saw the issue in terms of reallocating resources within the personal social services, although many readily recognised that priorities there did not favour the dependency groups. Work with children and families along with court work (probation work) largely took precedence. Just over a fifth felt that no sectors should lose resources while the remainder were not able to pass an opinion. In no case then did a social work manager recommend a course of action which would actually impinge on their 'territory' where such decisions would be much more difficult to make (as their NHS counterparts found).

Social work managers exhibited a greater spread of views about whether any particular group should be singled out for priority than most other professional groups. A majority (60%) were prepared to make a single choice. The physically handicapped, followed by the mentally ill and then the mentally handicapped were the groups most often chosen:

> I think that there's a lot of sympathy and a lot of push for help for people that are physically handicapped - I think that's an obvious thing ...and maybe I'm part of that [agreement]. (Home help organiser 12EL)

This contrasts strongly with preferences exhibited by NHS respondents - NHS managers, for example, favoured the elderly. It might be that the visibility of elderly patients occupying hospital beds created pressure on NHS managers which was not so apparent for social work respondents.

When asked whether or not resources could be re-distributed to greater effect within the priority groups sector as a whole, no social work managers disagreed, and indeed almost two thirds felt that this might be possible. The remainder were non-committal. This was a pattern somewhat similar to that of the NHS managers. However, unlike NHS managers, just under half of social work managers suggested that resources could be transferred directly from the NHS to local authorities for the care of the dependency groups:

> Resp.In absolute terms we are very short on [services for] mental handicap. It's a fairly rewarding group to deal with

and that could be done, I'm convinced without any more money. I know the health service don't agree with that - they say they need extra money for hospitals. But I think if some device could be - if you had people who agreed about the objectives....

Int. So you would be saving on hospital - cutting down on hospital places?

Resp.Yes. And then you could really save on hospital places.

Int. That would imply a transfer of resources, then, would it?

Resp.Yes, direct.

Int. From one service to another?

Resp.Yes. (26AB)

And unlike the case of NHS responses, a number of respondents (almost a quarter) suggested that resources could be transferred from institutions to the community for their care:

> If people are going to derive a benefit from the community then that's the thing [transfer of resources] and obviously the more hostels we have for the mentally handicapped to prevent people going into long-term care...I'm all for that ....I think to some extent it should be our responsibility not in the way of empire building and obviously you want close co-operation. (Social work middle manager 11EL)

and

> I think we need to shift resources from the health service to community based services, rather than try to build up some kind of community resource and let the present level

of medically orientated services continue.

(Divisional officer 32AB)

Again, many placed emphasis on the need for greater collaboration both between agencies and between professions, but at the same time just about half felt sceptical as to whether that was a realistic goal. The following remark of a director of social work is apposite:

> People who are of the most senior positions in both services have very heavy workloads and very demanding, consuming workloads and it is easier in that kind of situation to mistake goodwill and good relationships with actual operational co-operation and - now operational co-operation that involves other people is always something that you're going to get round to when you've discharged your own daily round of operational activities and I think conceptually that's a very difficult thing to grasp. (10GL)

Social work managers supported (half positively and a further third 'mildly') the suggestion that more resources should be diverted towards prevention and the promotion of well-being (this of course included crisis prevention defined in social work terms as well as health promotion *per se*); very few voiced any opinion against the option. The response of a divisional officer was characteristic - in her division, she saw preventive work with children as an example, together with the establishment of a primary care social work team:

> Our intermediate treatment team does work with a very very large number of children who have already demonstrated difficulties and we are preventing them coming into residential care....and I think the primary care team was an effort to do preventive work...it's approaching the preventive end of the spectrum, the early detection end of it. (32AB)

When asked whether or not better use could be made of existing resources - a sensitive question for managers who are the husbanders of resources - they replied in much the same way as their NHS counterparts. A quarter believed firmly that it was impossible but 60% believed that some improvement could be achieved. It was mostly lower level managers who felt this and almost no-one felt that cuts in administration could be made. They suggested improvements in the way services were organised: there could be some rationalisation of services:

> I think, yes, I do. Although I think, because of the financial cuts that we're starting to do that...I think for ourselves, as far as OTs are concerned, probably we were very lax...we tended to be very generous in giving out equipment and not checking to see, perhaps, if it was used properly. You know I think we're just being strict with ourselves I think that again that's come because of cuts and it's a good thing. (Head occupational therapist 04JB)

c) Community care

Social work managers differed markedly in their definitions of the term community care from all professional groups considered so far. Just over half of them saw it as meaning care in one's own home:

> I think the way that we presently talk about community care would be domiciliary care, em - I think there's a growing awareness of the fact that what we mean by community care is care within the community by the community. (Divisional social work officer 10EL)

A small number did not define it and the remainder (just over a third) divided equally between any care outside hospital or any care outside hospital and old people's homes. This contrasts sharply with NHS respondents who tend to define it in the more inclusive and all-embracing sense. It might be that social workers saw the concept in ideological terms and that precision of definition was more important to them, while for NHS respondents, the term was a convenient catch-all phrase or a concept that they had not considered in any great depth.

The social work managers wanted more input from the health service in providing care for the dependency groups. Interestingly many of them wanted more institutional care to be available from the NHS. They saw the problems of heavily dependent people in the community, lacking care and needing in their view greater NHS responsiveness. They looked for more domiciliary nursing services and more day care in day hospitals:

> Day hospital care I should say...this cuts down on the high cost of providing in-patient care. Quite simply, it is not necesssary to keep people in beds for so long.
>
> (Principal hospital worker 29JK)

However they also looked for more local authority services - especially those provided at home or in the community (lunch clubs, or more home helps, for example):

> Oh please never cut back on home helps, give us more of them and turn them into a different kind of animal. I'd like to call them home care workers.
>
> (Principal officer - hospital and health 12GL)

Fewer asked for more local authority residential care. The spread of responses in this field showed that managers had a broad perspective; they did not focus narrowly on one area of the service.

d) Working life

Social work managers scored higher than any other group when asked whether they felt they worked under constraints. Almost all of them reported difficulties and chief amongst them was the problem of having to cope with shortages and cuts. A director of social work said:

> It's an illusion to think that times are good and there's a lot of fat around in the public services...there's no doubt about it, that public services of every kind are cutting into the margin at the moment and when you cut

into the actual margin of non-provision - we actually ration some services now by levels of misery. (10GL)

Lower level managers complained of heavy workload as being a problem:

> There are more and more aspects [of work] in the area team ...in all kinds of ways, different workers, group workers, community workers, welfare rights officers....there are more and more calls made upon your time as an area officer, in consultancy, in decision-making and involvement which you have here, there and everywhere.
>
> (Area officer 19DW)

As with NHS managers, social work managers also said that the nature of their work presented difficulties - being responsible for the service at such a difficult time.

As far as working relationships were concerned, the managers reported most difficulties with NHS consultants, followed by GPs and field social workers. Problems with consultants frequently revolved round the latters' ability to restrict access to hospital care for social work clients that were in need of it (in the social work managers' eyes). This was often the case in relation to elderly mentally infirm clients. Other instances reported were where consultants failed to understand the role of social workers:

> Mental handicap is one that comes to mind [where there are problematic relationships]. Psychiatry is another one. Now that can be a problem from time to time... I think it's a question of - you know, social workers' role in relation -

I mean, it's not all psychiatrists would feel this way, but some of them feel that social workers perhaps shouldn't be involved in this, or should be involved in that.

(Depute director of social work 27AB)

There were particular problems for social work teams based in hospitals. The personal power that consultants held in terms of being able to withhold or allow access was, they felt, too great. Differences of opinion stemmed from differences in approach or in interpretation of roles. Senior managers did not have much contact with GPs, although some did hear of problems at one stage removed:

I think the general practitioner is one of the most difficult ones. Simply because by the nature of his employment and the fact that he's a contractual employee of the health board and not a full employee as the others are. This means that if he's going to be a team man, he's a team man who can opt out or worse still can dictate his own terms which can often dictate against good teamwork. (Principal officer- hospital and health 12GL)

Lower level managers had more contact and occasionally came across particular problems:

Mainly a poor quality of referral, a poor assessment of a referral to us - a GP writes a two line letter 'please assess for eventide care' and that in our terms is insufficient. We'd like a bit more co-operation about giving detail.

(Area manager 16JK)

While they cited problems with consultants and GPs as individuals, social work managers did not mention health board officers in the same way. They did, however, perceive many problems with 'the health board'. They found liaison difficult; each side defined problems differently and each had different priorities:

> I think there's a lot of mistrust between the two groups that ought not to be there. But I do think that institutions, whether they are health service institutions or whether they are social work institutions, become little sort of kingdoms, and see anything outwith those little kingdoms as being inferior, threatening.
>
> (Divisional officer 32AB)

The problems which they mentioned regarding field social workers were insignificant by comparison with the inter-agency and medico-social work problems that they described. These were mostly to do with relatively straightforward line management problems or problems sometimes to do with the hospital social work/community social work interface:

> The hospital workers have been understaffed for quite some time .....the principal officer for health will contact the area and say, look, we are in such and such a position, would you mind accepting cases from us.... there's a bit of discussion that goes on about that. Maybe the social worker [in the community] would feel that he might not be able to cope.... but by and large it sorts itself out.
>
> (Area officer 16DW)

Social work managers then were not dissimilar from their health service counterparts in a number of ways. They too lived stressful working lives bounded by frustrations caused by the lack of resources and the entrenched interests of other groups. They did however perhaps perceive the issues under study in a less immediate way than the NHS managers; the most pressing demands made on them by the social work service were perhaps more to do with family poverty, child protection and their court and probation responsibilities than with the needs and problems of the dependency groups.

SENIOR SOCIAL WORKERS

Twenty senior social workers were interviewed. Although they can be classified as first line managers, it was decided to examine their responses separately from other social work managers because most of them are involved with practice to a greater extent than other managers. They straddle the manager/practitioner divide and so occupy a special position.

a) The moral dimension

Half of the senior social workers clustered around the middle of the family - state continuum, although more opted for the 'family with professional support' than the 'state-family partnership' view:

> I think I'd have to answer that in terms of the existing situation where you have family, right? I think if you have the family unit as a unit of society, you're prepared to work with that unit, then the balance should be between the family and the institution in order to maintain it. I mean with ardent hope the emphasis being on the family coping with the situation as best they can. (02JK)

But choices spread widely; a fifth went for the 'primarily state' option:

> I think families should only do it if they want to do it. I don't think we should ever rely on families to do it....

it's ultimately a state responsibility...I think that's right. (10AB)

A small number chose the option at the opposite end of the continuum - 'primarily family':

I think the prime responsibility is with the family. I don't think there's any question of that. (04JKB)

This wide distribution, coupled at the same time with the heavy choice of the 'family with professional support' option characterises senior social workers as different from their other social work colleagues as well as the NHS respondents.

In their views about public expectations and the public's readiness to take responsibility, senior social workers differed less from other respondents than on the family/state issue. Just under half of them believed that people expect too much of the services which is similar to both their social work manager colleagues and NHS managers:

I suppose on the whole too much, but I'm not happy to say either one or the other....I think quite clearly they often expect too much but I think it's quite difficult to say about people in this situation. (03DW)

Likewise, similar numbers - roughly one third - believed that the public does *not* expect too much:

Maybe they should be making *more* noise...
well, I think that there still are unmet needs in terms of support say to the parents of handicapped children or

you know grown-up. relatives of handicapped adults, the relatives of elderly. (07JK)

On the willngness to take responsibility issue, more of them believed that the public is willing to care than not, but well over half were not prepared to generalise about the matter which makes it difficult to draw comparisons with other groups on the positive choices. Many of those who were not prepared to generalise said it often all depended on the particular family circumstances of those involved - whether the dependent person was loved, whether the family had the economic capacity to care or how tolerable the strain of caring was:

> Families vary tremendously from one end of the continuum to another - some of them, as soon as the patient is in hospital, they just don't want to know anymore..... you get the mixture of others who have really just had enough and it is beyond their ability - I mean they have been coping with an intolerable situation for a long time and as soon as they are relieved of that, they can't face up to taking it back on again - and we can well understand that. (14AB)

Senior social workers were extremely positive about the role of the voluntary sector - more so than any other group (apart from basic grade social workers). A third were in favour on a conditional basis and almost two thirds were in favour without condition:

> I'm very enthusiastic about that [the voluntary sector]... we do have good relationships with all our voluntary organisations locally and they are very good. (03JBB)

They favoured voluntary sector effort for a range of reasons: that it was innovative, that they favoured the principle of voluntarism, that it was important to harness resources that were available in the community:

> I think very often the voluntary sector can push things forward, be a bit more creative in their approach and can show the way in many ways but I would not say it should be owing to them to take it on lock, stock and barrel...I think that type of creative, imaginative, self-help...I don't think a paternalistic kind of view to caring for the needy is particularly helpful for them, in terms of their own self-esteem. (14DW)

At the same time they also felt that it should be supplementary to professional effort. And a few respondents questioned the motives of some volunteers:

> I think there's a role for the volunteer. I would never discourage volunteers, as long as they're not the do-gooder type. (19AB).

b) The priority policies

Senior social workers displayed similar views as their more senior managers on the priority policies. Almost two thirds approved them although twice as many expressed some equivocation than those who expressed full support (social work managers were more evenly divided):

> I'm surprised to hear they're a priority because I would feel that the resources available for these groups has actually diminished...I think it's difficult - are you meaning priority as opposed to acute, medically-ill people, that kind of thing? I find that a very difficult decision to make...because everyone is needing a similar service...I mean I think I would push the priority for them. (11JK)

Many more of the senior social workers (a quarter) than their managers were either opposed or wanted a more even treatment of all sectors:

> I wouldn't necessarily say priority; I think they should have their fair share and I think that's what they haven't had. (12JBE)

They contrasted strongly with field workers (both health and social work) on this issue; a managerial spread of responses seems to emerge. One respondent for example suggested it was better to review services and assess need more accurately before deciding to shift resources one way or another:

> My answer to you would be that many of our decisions in social work are based on assumed needs.... you see the answer to me is assessed needs - really, do we have a problem of very elderly people, have we a waiting list, have we a queue? Whereas if we were more objective ... that's a far better way. (18AB)

On the issue of which sectors should lose however, such similarity disappears. While almost the same proportion of senior social

workers as their managers seemed to agree either that it should be the acute sector that should lose, or that no sector should lose, almost half of all senior social workers could not make up their minds or were unwilling to comment. They did not show the diverse range of choices that their managers did.

But on the question of whether or not any one group should be singled out for preference they exhibited similar responses to those of the managers. A majority was prepared to opt for a particular group but unlike the managers, senior social workers more often chose the elderly (the group frequently favoured by NHS respondents):

> It's hard to say. I would say that from my knowledge of the situation in terms of geriatrics and psycho-geriatrics in this region there obviously aren't enough resources there - because there are terrible problems in the community... so I would certainly say that was the area I could identify most readily, most easily. (11AB)

Then followed some of the groups selected by social work managers - the mentally ill and mentally handicapped.

Just over half of the senior social workers felt there was room for shifting resources within the chronic sector - either by transferring resources from the NHS (but not in the opposite direction) or from institutions to the community:

> If you're going to have these resources in the community, and therefore you're not going to need these big residential

hospitals, there can be things like that [a transfer of resources] and could some of the workers even be transferred to give the support. I haven't really thought about that one, but just thinking about it quickly, I feel that it was feasible. (16AB)

There were voices against that proposition, however:

Well, before I came here, I had really thought that the provision of a thousand psychiatric beds on this site was a vast over-provision - that was my gut reaction. And I'd have to say after eight weeks, it's quite clear to me that although there are some people who could be discharged if there was something within the community, on the whole the people who are in here, the core of the long-term people, require this sort of provision....so I think the answer is no, there isn't that much potential for closing down bits of institutions to release money for other things, I'm sure. (03DW)

More than anything else they favoured better inter-agency collaboration - though there was much less support for greater inter-professional collaboration:

I think really it's mad that we both battle and defend our lines of defence when really I'm sure we could jointly fund and double up in some areas because the border, I mean the boundary between what we deal with and who we classify as our responsibility and you know who the NHS classify as their responsibility, the boundary is so close and at the same time it's a lot of wasted

> energy fighting over who's taking the responsibility for this that it does seem folly not to co-operate and to, you know, join forces in some of these areas. (14DW)

And as in so many other cases, there was a substantial degree of scepticism voiced over the possibility of improved collaboration. The respondent quoted above who said resources and workers might be transferred from hospitals to the community went on to say this might however prove difficult:

> but I don't think it's realistic - I can't imagine the hospitals ever , they would resist.... I think certainly more collaboration surely is beneficial and it should be aimed for because you've more idea of what you're each trying to achieve. You don't want to duplicate things.... I suppose you are part of different structures and each can be so protective of its own. (16AB)

Senior social workers, along with their other social work colleagues, were positive about the value of shifting resources into prevention and promotion - just over half supported the suggestion mildly and two fifths supported it positively. Very few expressed scepticism as did many in the health service. This may reflect the different interpretations put on the meaning of prevention. Social work respondents saw a whole range of social intervention measures as coming under the 'prevention' label while health service respondents tended to limit it strictly to health service strategies - health education or technical measures such as screening. In the case of

senior social workers, they quite clearly saw it as meaning predominantly social intervention/crisis prevention measures such as back up for families under stress and the like:

> I suppose some of our work is preventive in the sense of quite a number of families we work with had one child in care before we even get there....our job is to ensure that the other children don't end up in care as well so I suppose it's preventative to that aspect as well. (26DW)

Over two thirds believed that it was possible to make better use of existing resources. Again, they reflected both social work and NHS managers' responses. None of them felt this could be done by cutting down on administrative costs or by making savings on the use of equipment and so on. The only suggestions they made related to the possibility of improving the way services were organised - the 'rationalisation of services' suggestion:

> Within the social work department, I am not satisfied that the best use is made of social work time, that the best use is made of the very precious places we have in day care, for example. Yes, I'm sure there's always scope for that. (10AB)

c) Community care

Senior social workers' definitions of community care were typical of the mainstream working definitions that social work generally employs. Just over half opted for the definition of community care

as meaning all care provided outside hospitals and local authority old people's homes:

> I would think of community care as somebody coming out of maybe an institution back into the community, or if somebody in the community would help with somebody to prevent them going into an institution.....[they would be living in their own homes] but in the case of some of them it would need to be a hostel or a house or something where they'd come, but they would still be in the community. (15AB)

Thus it included hostels, group homes, half-way houses and other community based provision. Just over a third however defined it more strictly as care within one's own home:

> That's how I would define it as - you know, monitoring the well-being of a person within the community, either at their own home or in the homes of, you know, relatives on whom to some extent they are dependent. (07JK)

The spread of their responses resemble basic grade social workers' responses more than any others and this may reflect their close relationship to the field.

When asked about how might services be improved, senior social workers concentrated on their own departments' field of responsibility. They wanted to see improved domiciliary services, better coordination of services within the community, a more imaginative use of residential care (for respite care for example), more group homes:

I mean at all levels, we could do with much more - we could still do with more imagination being used in the home help department.. and in the day care centres....There's more scope for kind of - I don't know whether it would be voluntary or statutory, but getting other kinds of stimulus into people's lives, like outings... we could be giving more scope in terms of holiday admissions... it gives relatives - relatives might cope for longer if they have more breaks through the year. (10AB)

They were prepared to make suggestions for NHS services to a much lesser extent, but amongst those suggestions were some for improved access to hospital care for those clients who needed it (similar to social work managers' views about the limitation on access to hospital care):

I would like to see more day facilities for all the dependency groups that you've talked about - psychiatric day hospitals, but for all dependency groups, they all need day facilities of some kind, being provided by social work, health service or whoever is the most appropriate. (03DW).

d) Working life

Senior social workers resembled field workers in their reporting of the constraints they felt they work under. Chief of these was that of workload - just as NHS field workers reported:

Shortage of social workers in this team has been quite

critical for a number of months, so the pressure people work under is quite severe at times (11JK)

After that they reported that lack of resources or cuts in resources was a major problem. The same respondent went on to comment:

> I think the money side comes in in that there seems to be a shortage of resources of all kinds to back up social work with people. You know your basic case work and group work is done but sometimes where money is needed for this and that, or care is needed, it's difficult to get people in. (11JK)

However a number also discussed the problem of being placed at the point where the field came first into contact with management. As first line managers who maintained links with the field they had the problem of representing both in opposite directions .

Difficulties in working relationships with other professionals followed the same pattern as those of their managers. Relationships with consultants were the most problematic followed by those with GPs and then with field social workers. Problems were often related to lack of resources or differences in diagnosis:

> The problem seems to be lack of hospital accomodation for people whom we consider, and the GPs consider, require hospital rather than residential care. That's particularly true of the psycho-geriatric patients. There are people in the community whom I believe would be in hospital if there were beds available. (27DW)

and

> We tend normally to go through the GPs because it's the GPs calling in the consultant.... it's in the psycho-geriatric field that there's coming and going because that's where the most grey area about whose responsibility a person is.....well, I was trying to say we feel people have to be able to make the decision to come into our care and where either people are refusing or we feel they are so confused that they cannot make the decision, we usually refer back to the hospital and to the GPs - and sometimes they are still saying they are suitable for residential care. (11JK)

The familiar differences in attitude and orientation characterised relationships between the senior social workers and their health service colleagues. One spoke of difficulties, for example, with domiciliary nurses and with health visitors:

> Domiciliary nurses, there have been feelings, and health visitors as well, that perhaps they're doing the same job and there have been some feelings about that.....there is a great deal of common areas about our roles, a lot of confusion too that we pick up, we feel they do the same job as us and we have to try and explain that it's not quite the same. (13AB)

But while senior social workers and their managers cited consultants and GPs as individuals as being difficult, consultants and GPs tended to see social work management as a monolith - 'the social work department' - undifferentiated but the source of many of their problems nevertheless.

Senior social workers, ironically, also cited the social work department as being a source of problems. If they were hospital based, they often claimed that they felt isolated from the mainstream of the department; or if they were mainstream, they felt that hospital social work teams had 'gone over to the other side' - that is, the health service and its ideological attitudes. One hospital-based respondent described the different pulls that they were subject to:

> One of the problems to some extent is that we're part of a social work department but we're in a secondary setting, so we are serving in a health setting....well, I don't know that it's totally understood by our own senior management.... the pressures on medical staff which one can appreciate in this setting but perhaps not so easily appreciated by the teams of the local community based social workers when they are arranging emergency admissions... I really don't know, I think it's a lack of understanding of each others' roles and I think if you're on the spot, you can have sympathy with both points of view, whereas maybe our own district colleagues are not so closely involved. (14DW)

In the larger social work department, some expressed concern that its size was overwhelming; there was too great a distance between districts and headquarters:

> I often think there's too many tiers in the organisation. I mean, I'm not sure about that. There's districts and divisions and the region.... probably a great deal of distance between the people at the top of the organisation

and the people at the bottom which is not particularly kind of helpful or enabling. Yes, that's probably it.

(26DW)

There was some sense of powerlessness, then, felt by a number of the senior social workers. They were managers in the sense that they led teams, but they had little control over decisions which affected both them and their teams.

BASIC GRADE SOCIAL WORKERS

Thirty eight basic grade social workers were interviewed; some were hospital based, but the majority were based in social work teams in the community in area or divisional or district offices.

a) The moral dimension

As with all groups, most responses clustered in the middle of the continuum, family - state; in the case of basic grade social workers however, they were weighted substantially towards the 'primarily state' and 'partnership' options when compared with all other groups (60% as compared to 46% amongst social work managers, the next largest group):

> I think we live in a society which has admitted by stating its democracy and all the rest of it that the community is responsible for the community rather than the individual [being responsible]...I think I have to say the community and the state. (10DW)

and

> I think that it has to be shared. Generally speaking I think that relatives and families have to take a greater share in the care and responsibility of the weaker members of the family because I don't think the state can cope... I don't necessarily think it's the right thing for them to do, but

> I don't know what [else can be done] in the present circumstances. (06AB)

and

> I think it should be shared and it should be a choice. I think often a family would choose to take prime responsibility with support built in, but I don't think there should ever be a case for the choice being forced on them. (24JK)

In addition, they held very positive views of the public; only a small proportion felt that the public were not prepared to take responsibility (less than one tenth) with two thirds believing that they did:

> I think mostly they are, quite amazingly so - to a quite amazing degree. I really think so. (02DW)

and

> I have generally found the relatives of a dependent person to be quite responsible. To have lived with the problem for a long time and only at the end of the day to ask for help. Because generally lots of people feel guilty about asking for help. Guilty that they're not able to cope with this dependent person. (13JBE)

Social work managers were the group which mirrored them most closely on this issue, followed by NHS managers and hospital consultants. On the matter of whether the public expected too much, almost half of basic grade social workers felt that they did expect too much, but not in the judgemental fashion found amongst groups like GPs and, to a lesser extent, health visitors. And indeed, half

of the total felt that the public did *not* expect too much - far bigger a proportion than amongst any other group. Indeed, a number said they felt that the public expected too little:

> I do think too little, although having said that, they are not forthcoming. But I think they should be geared to demanding a lot more, but there is pressure groups needed to make sure that the services are forthcoming. (24JK)

Basic grade social workers rated high in the support they gave for the voluntary sector, only slightly less than the total support given by health visitors and social work managers. One respondent, for example, had an idealistic view of the voluntary role:

> I think it would be good if there was a replacement to state support but quite honestly I don't think they would ever manage that because most people are tied up with their own problems and not everybody's got time to do voluntary work. (05JK)

But unlike health visitors more of them gave qualified support rather than unconditional support to voluntary sector involvement:

> A supportive role. I suppose that sounds awful, but I do see them as supportive.... some voluntary effort should be encouraged. I think the voluntary effort that should be encouraged is visitation to patients in hospital... befriend a patient, befriend a child. (07DW)

For the most part they saw it as supplementary to professional involvement although some favoured it for its innovatory possibilities. Very few voiced opinions against the voluntary sector

although one respondent mentioned union opposition to it: that the statutory services should be providing the services which voluntary organisations were being encouraged to provide.

Field social workers then were in favour of state and professional involvement; they did not hold judgemental views of the public. On the contrary, they believed the public was ready to shoulder its responsibilities willingly. At the same time, they were not ideologically opposed to voluntary sector involvement, although they saw it quite clearly as supplementary to professional involvement. In certain respects, they stood out distinctly from other of the groups under study.

b) The priority policies

Basic grade social workers were amongst the most positively in favour of the priority policies. Only health visitors responded more positively. Over half of the field social workers gave the priorities full support with another quarter supporting them 'mildly':

> Yes, I think society has a responsibility to cater for the disabled, the disadvantaged to some extent and the deprived. The elderly, the chronically sick, the people who require additional support and services, and none of them can help being in those states. Old age is something that happens, chronic mental or physical disability, these are things over

which people have very marginal control, therefore I think if we are talking about a welfare state, then we should be spending a good percentage of our time concentrating on those people that do need our help. (08DW)

and

Yes, I think - I think they should until they have caught up. I don't mean indefinitely, because there are other groups that need help certainly. There are lots of things that could be done, like screening more women and perhaps better ante-natal services... but I think these lot do need priority until they have got up. (02DW)

Very few either opposed them or said that there should be balanced treatment of all sectors. However, amongst those who did disagree with the policies, it was often felt that poor families and abused children should take precedence.

Front-line practitioners, with the possible exception of the GPs, were the groups most ready to support the policies - and the groups least burdened by decision-making responsibilities with regard to resource allocation. This is reflected perhaps in social workers' reluctance or inability to single out sectors to lose resources. Almost two thirds were either not prepared to choose or said no sector should actually lose resources:

That's difficult to say because I'm, I mean what I'm coming to - you could say what I'm confronted with every day are probably people getting more priority anyway - so

it's quite difficult to answer.....to actually say what doesn't deserve is very difficult...I think anyone you come in contact with deserves to get a service of sorts, obviously planning is difficult, I can imagine. (02JB)

A small number suggested non-medical or non-health service areas as candidates for resource withdrawal:

I sometimes get annoyed at the priority which is given - and it's terrible to say it in social work - priority which is given to offenders and the little priority that is given to the parents looking after mentally handicapped children, you know. A priority in this, in any, office is court reports and children's panel reports and yet we have got parents caring for mentally handicapped adults in their home that are waiting allocation for ages and I just - possibly they [offenders] could slip down the priority list. (04JK)

Like senior social workers (their team leaders), and unlike their more senior managers, the field social workers said that the elderly were the chief targets for concern - although just over half of all of them said no one group should be singled out for preference:

No - it's difficult to separate. I think if a client is in need, no matter what the problem is, their need is just as great as the other client groups. (06AB)

Amongst the remainder, the elderly ranked first, followed by the mentally handicapped. However, these were both groups that were

acknowledged by many to be of low priority in the existing state of affairs and it was recognised that it would be difficult to change attitudes in their favour.

A greater proportion of basic grade social workers than any other group felt that improvements could be made by reallocating or re-ordering resources within the dependency groups sector. Almost three quarter of them felt this could be possible - substantially more than amongst other groups. One respondent felt strongly that there could be improvements in the way health and social work services worked together:

> I think maybe a mixture of both [transfers in both directions]. Because I think what's missing now, is that there seem to be two distinct services very much, and while there is communication and sharing, maybe it could be a lot better really than it is. Because I am certainly not aware of being involved in a sort of wide caring service, in a way which includes the health services as well. I think to do a proper job - maybe I shouldn't be talking like that, you know. I suppose that's why I said that the primary care team [a team of social workers based in a health centre] may be the way of the future, that's what's going to happen, or should happen. (02AB)

There were more suggestions amongst this group that resources should be transferred from institutions to the community; there were positive views about the ability of the local authority to care for the elderly and the mentally handicapped rather than the health

service. A number of respondents felt in conjunction with this that resources should be transferred from the NHS to social work for this purpose:

> I think there should be much more transfer from health to social services - from the institutional care of whatever kind, services to maintain people in the community for the mentally handicapped that kind of thing, the mentally ill. My view would be the more co-operation and understanding between the two parties. (05AB)

At the same time there was also some support for the amalgamation of long term care services under a joint or single authority:

> I think it would be a good idea if they could, because I think there is definitely, I know, a grey area in the middle where they really should be able to liaise and probably joint funding would help in fact.....I think it would probably help if they were amalgamated for community care provision [but] I think you'd have a difficulty with one being local government and one being national. I think you'd have just the political difficulty there. I'd like to see it if you could find some way round it. (04JK)

Many argued for greater inter-agency collaboration and to a lesser degree for more inter-professional collaboration, but - as so often - most were sceptical of how possible either of these could be achieved.

Field social workers, like their other social work colleagues, felt positively that resources should be put into prevention. They were less sceptical about its effectiveness than most health service groups. But like their other social work colleagues they saw it as predominantly meaning crisis prevention and social intervention strategies - rather than the health service interpretations of health education and technical strategies (although a fair number of field social workers mentioned health education too):

> In social services, in relation to child care, again, I think there's a tremendous amount of resources and finance been put into that but in terms of the dependency groups - no - not enough....to reach people right from the start. I mean housing would be one of the fundamental needs for physically handicapped, mentally handicapped and the elderly and that's all coming under the same kind of approach. (21JK)

Almost three quarters felt that it was possible to make better use of resources although they frequently found it hard to be specific:

> I'm always reluctant to be complacent and say 'Oh no, you know, resources are OK. I don't know if you're going to ask me how could that be done? But you know it needs a bit of thought. But I think if we sit down from time to time and think about how we are using resources, we could always improve. (05JKE)

In this, they resembled most other front-line or junior staff. Managers, on the other hand, registered less optimism that this

would be possible (after all it would be they who would be charged with the duty of achieving this). But like their managers, field social workers saw possible improvements as lying within the realm of service organisation and rationalisation rather than through cutting down on administration or making savings in the use of equipment. A number, however, suggested that improvements could be made by raising standards or fostering teamwork:

> Better use can always be made of existing resources... well, my own subjectivity, waste I see here: there's meetings about meetings about meetings. And sometimes you have a meeting about the last meeting. I feel that could be cut down. I feel at times there's waste owing to lack of teamwork and communication. The left hand doesn't know what the right hand is doing... and more liaison....at all levels. When you are cutting costs, you start, you do, you start up at the highest mountain and down the way you know. (07DW).

c) Community care

Basic grade social workers resembled their team leaders in their definition of the term community care. Almost two thirds employed the working definition of it as meaning everything outside hospitals and old people's homes:

> I think, I think that community care means, for me, it is being outside the hospitals or outside any institution,

> and I would include in that old peoples homes [as an institution]... no wait a minute, having said that, I think it depends on the institution as well. If the person is in their own home, when you say own home, it can be a group home...I'd include group homes; I'd include sheltered housing certainly. I was only making a specific comment about old peoples homes. (09JK)

A further quarter restricted its definition to the 'own home' option. On the whole, basic grade social workers seemed to have a familiarity with the term and the nuances of the term. A number talked about it in philosophical terms and suggested that the health service was lagging behind social work's understanding of the concept. This is reflected in the range of developments they said they would like to see in service provision. They wanted better day centres, improved communication between home helps and social workers, more domiciliary services, better rehabilitation services, more hospital places for those who needed them, more day hospitals - the list was long, and respondents made a number of suggestions each. Unlike health visitors, for example, they *did* seem to have a coherent view of what community care provision should and might look like and of the difficulties of achieving it:

> I would think community care can mean hostels and houses, yes, but wouldn't include old folks homes - I think that's very much institutional care unless they're in very small group homes, but there's not many of them around - I haven't really seen one.....I don't see that it's gone [far] to any extent at all. I think a lot of people,

management especially, are very keen on the idea of community care because it means less money. It all goes back to money, that's all right, but in actual fact they're cutting back on home helps at the moment .....community care in various areas of the work is actually getting smaller at the moment with the squeeze.. ...well for example, in terms of health services, one problem I haven't mentioned is probably the centralisation of the health services and I don't expect that that is very helpful or handy for chronically sick people - if they've got to go further to get to their doctors and nurses and that's because it's become less local in most areas. (11DW) .

d) Working life

As with most respondents, they reported a number of constraints on daily working life - although not quite so high a proportion as their other social work colleagues. They reported problems mostly to do with scarce resources and cuts in resources, along with heavy workload (the familiar complaint of front-line practitioners):

Up till recently we had a terrrible shortage of staff which created a lot of pressure on us. There is only two of us here and you found yourself just overloaded with work. ....it's all just lack of money and this department is especially bad, we didn't have very much money at all, even for bus fares and things. (05DW)

Feelings were expressed that teams took on too much; caseloads became too high and standards suffered:

> Pressures and constraints? I would say the fact that we are quite a small team and in a sense we don't say - it may sound contradictory - but we don't say no to more of the work. I would far rather we prune it and have smaller caseloads....but we are trying to take on as much as possible ... yes, you're doing the work, but it is not up to satisfactory standard. (24JK)

In terms of working relationships with other professionals, the reverse side of the picture described for GPs, consultants and health visitors emerges. Each of those groups reported most, or almost most, difficulties in working with field social workers. Field social workers, it emerges here, found exactly the same to be true in reverse. They found most problems in dealing with GPs:

> GPs are forever saying they haven't got time and that's particularly noticeable in confer- well, the non-accidental injury case conferences we have where the GPs are supposed - through the agreement, you know, the agreement we have to attend and take an interest.....and it's not very often that a GP will write even a report or a letter or their commitment, you know, that side of it. (10JBE)

They resented the GPs' gatekeeping role and would have liked greater direct access to some of the services. Differences in professional orientation was a continual problem - not only with GPs but with many health service professions:

> The poorest ones [relationships], I would imagine, are with GPs. Some of them - I mean some are very good - but some seem to resent...or be sort of unaware of what the social work role is - and sort of take all their time to feel that what they are doing is all important and social workers have no part in that. (02AB)

Hospital based social workers found they had major problems in dealing with consultants who failed to understand the social work role and expected social workers to perform mundane tasks below their professional competence or refused to involve them in their decision-making:

> I think this is one of the most difficult areas - geriatricians specifically.....usually if I'm speaking to a geriatrician it's to ask for an explanation of a decision that a geriatrician has made that a person will not be admitted to hospital and frequently that is an area of concern when an elderly person is left at risk in the community because the social work department and the geriatrician could not reach some kind of agreement as to whose responsibility the care of the person is....I think it's a terrible situation when it happens that the structures are so rigid and so separate that it hasn't been sorted out by now. (21JK)

Community based social workers had problems in relation to health visitors. These mostly revolved round territorial boundaries - the social workers perceived this to be so more than the health

visitors. Social workers saw health visitors as intruding into 'their' professional territory rather than the other way round:

> I would say sometimes health visitors and district nurses have unrealistic expectations of social workers. That is to say that sometimes I will get a phone call saying that a particular health visitor hasn't managed to get access to a family, do you have any knowledge? They are a bit worried.... I like to know what the information is being released for. I don't think it's quite as simple as phoning up and saying what do we know about a particular family... they are then expecting ....we can go along and say, why aren't you giving the health visitor access? I don't see that as my job - to hound people.....[There are things that are] her remit. If she is having difficulty with it, I don't see that it is then for me to take it up on her behalf necessarily. There may be occasions when I would agree to it, but I think there are sometimes when it would be very inappropriate. It would be putting additional pressures on them, pressures on the wrong areas than I am wanting to put pressure on. But focus it towards a goal that we are working towards - and a health visitor cutting across that, she can do it in her own right, that's fine. But not ask me to take it on. (24JK)

According to the views expressed by many respondents, the primary health care team was seen as something to be worked for but in practice was not a viable entity; it was riven by differences in

professional attitudes and expectations, by resentment at the overbearing attitudes of one profession (usually the GP) to another (usually the social worker) and by jealousies over role definitions and professional boundaries.

Field social workers also reported difficulties with a greater number of other agencies than did other professional groups. They had difficulties with the housing department, the DHSS, with the education department, as well as with the health board and the social work department itself, or with hospital social work. This clearly reflects the broad nature of their responsibilities and the varied composition of the client groups with which they deal. It also demonstrates the competing demands made on their time (and on the resources of the social work department as an agency) by this wide variety of client group.

In spite of this wide commitment towards many client groups, field social workers showed an awareness of the issues relating to the care of dependency groups although they recognised the deficiencies in the social work departments' abilities to provide for the groups. They were keenly aware that in their departments' list of priorities, provision of services for the priority groups came along way down. And yet they frequently exhibited a view that they 'ought' to be caring more and providing a better service for them.

CHAPTER SIX

COMMENTARY: THE INITIAL PROPOSITIONS AND CROSS-CUTTING FACTORS

A. THE INITIAL PROPOSITIONS

Three propositions were initially put forward: one, it was proposed that professionals - that is, those in the business of policy implementation, either at the managerial level or at the level of practice - would have a different definition of client or patient need from that of the policy planners with whom the policies originated and from the definitions of the general public. Second, it was suggested that there might be differences in attitudes between professionals according to their location - as between Glasgow, Aberdeen and Elgin. Finally, it was proposed that differences might emerge between the various groups of professionals in the study.

1. The professional perspective

Official policy in relation to the dependency groups - that devised at Departmental (DHSS) level, confirmed (or proposed) by the party of government and embodied in policy documents, legislation and circulars - does not acknowledge the possibility that professionals (those involved in the implementation of policy at operational levels) may hold contrary or, at minimum, lukewarm views about the

content of policies and that these views may constitute a barrier to the effective implementation of policy.

It is clear from the evidence of this study that such views exist. There was by no means unanimous approval of the policies. Only two groups of professionals (health visitors and basic grade social workers) gave the policies unequivocal majority support. All groups except health visitors expressed some minority disagreement, whilst a substantial number in most groups gave only equivocal support or suggested that a balance has to be maintained across services for the care of all client groups. A divisional nursing officer was typical of many:

> I think they [the priority groups] should have a large consideration from the nation. But I am very mindful that the people who provide those monies to give these services have got to be cared for too, so we need those acute services as well... for the coronaries and lung neoplasms and things like that. (18JK)

Even where there was agreement in principle, substantial numbers from all professional groups (around about one third in many groups) stated that no other sectors should lose resources as a result of the priority policies. A GP, for example, said:

> I can't think of any NHS group that could really function with less money.....really, when you get down to it, it [high tech, transplant programmes] is a miniscule part of the the NHS budget. If you are looking for money to pour into building geriatric hospitals, psychogeriatric hospitals, you

are not going to get it, to my sort of understanding, by cutting back the transplant programme. (13JB)

Although the majority of respondents questioned worked in areas of the service dealing with the dependency groups, it is significant to note that many of them were not prepared to argue against resources going to the acute sector, despite policies which said such reallocation away from the acute sector ought to take place.

In addition, current policy which calls for greater reliance on the care provided by families and by the voluntary sector met with a mixed response from professionals. Most had no quarrel with voluntary sector involvement in principle, but many stressed that it should only be supplementary to professional input:

> There's a tricky line of distinction between a professional person and a voluntary person; sometimes the people that volunteer are just not the ideal ones.....I suppose there's the danger of them going too far when really professional help is needed. If they understand when professional help is needed to be brought in [then that's all right].
>
> (Senior nursing officer, 45JK)

Some feared encroachment by the voluntary sector into territory which properly belongs to the professionally run statutory services; some were dubious of the motives of some volunteers. Likewise they were sceptical of the degree to which families can and will take greater responsibility for dependent relatives. Many saw it as a matter of principle: that the state should be providing care and support and that families ought not to have to bear the burden of

care. Others argued that families are unwilling and unable to take on responsibility for care so that professionals will have to be called upon. It seems that a general rule can be stated: it is unlikely that professionals will concur with any policy which renders their professional expertise and jurisdiction redundant. The increasing emphasis placed on the role of informal and voluntary care is just such an example.

Professional scepticism about other aspects of the dependency group policies are revealed in other instances. The call for more emphasis to be placed on prevention and health promotion was accepted - but only to a certain degree. Those whose professional self-definition depends upon preventive and promotional work clearly supported the call; a health visitor said:

> I think that this is one of the things which is challenging about this job, and it's to try to get over to people what it [prevention] really is about.... to get people thinking that their health is their own responsibility.. I would like to see money put into prevention because I think when the long-term - you see that is the problem - it's easy to see the curative work [but not the immediate effects of prevention]. (27JK)

But most professionals tended to give only mild support or expressed a fair degree of scepticism. An orthopaedic surgeon was, in fact, extremely hostile:

> I think prevention is nonsense....we are talking all this prevention stuff and not realising the implications of it..

> Are we going to try an prevent people dying or something? In terms of the rest of the general well-being, I mean the community has never been so well...the elderly are elderly because the community is so well. (17DW)

Expectation of greater collaboration between agencies and between professions was welcomed but, again, most respondents were sceptical about how realistic it is to devise policies based upon such expectations.

To conclude, it seems clear that professionals do perceive policy requirements differently from the policy planners, especially those at the national level. It is a perception largely based on professional self-interest although expressed in terms of its being appropriate for both the service and the service users. It is coloured by a 'world-weary' scepticism about the feasibility of implementing over-optimistic policies. Professionals argue that organisations, other professionals and the public all present constraints which the policies fail to recognise or take into account. But they do not question their own constraining influence. Rather, their attitudes reflect their professional self-interest; they re-forge official versions of policy in their own interests or accentuate it where it coincides.

2. The importance of location

The study took place in three locations - one, a district of the large conurbation of Glasgow; two, the city of Aberdeen, the third

city of Scotland; and three, the small market town of Elgin in the northern part of Grampian region (of which Aberdeen is the capital). In terms of population size, placement on the urban-rural continuum, closeness to the seat of central government decision-making and other politico-bureaucratic factors (Glasgow and Aberdeen are main seats of local government and health service organisation whilst Elgin is not), the three locations were diverse but at the same time represented a characteristic range of Scottish settings. It was suggested at the outset of the study that attitudes amongst professionals might differ according to the nature of social, professional and bureaucratic relationships in each place.

However, according to the findings, very little distinctive patterning according to location emerged, especially in relation to key attitudes about policy and to the moral dimension of the debate - that is, 'where ought responsibility to lie'. This perhaps says more about the biographical history of the respondents in the sample than about the locations. Most respondents demonstrated a degree of geographical mobility during the course of their careers; attitudes which they exhibited at the time of interview were the expressions of professional lives not simply bounded by the locations in which they were presently found.

Where difference did emerge was in accounts of inter-professional and inter-agency relationships in one location as compared to the other two. That location (Elgin) was characterised by its relative physical isolation and its separation from the main seat of health

board decision-making and medical leadership (which was in Aberdeen, where the health board headquarters and the teaching hospital were situated).

There was no evidence of perceptions of any greater bureaucracy (or 'red tape') or anonymity affecting circumstances in either Aberdeen or Glasgow. As in Elgin, professional worlds there were still relatively small in contrast to the wider world surrounding them. Actors were known personally to each other even across agency divides. Decision-making processes within the NHS and within local authorities seem to be lengthy and tortuous wherever they take place. Where there was difference, it seemed to lie in the sense of isolation from the main seats of power felt by Elgin respondents. They saw the range of hills which lies between the county of Moray and Aberdeen with its hinterland as not only a physical barrier but as a block to their access to 'being heard'. One Elgin respondent, for instance, complained that they had little influence over decisions made in Aberdeen but which affected them directly:

> This again is where one feels so much that one doesn't have any control over one's own local situation as is instanced by the fact that we are going to get a second consultant anaesthetist next year in place of what has been a part-time general practitioner acting as anaesthetist ... but nobody has ever discussed with me how they managed this nor indeed have I ever heard about it officially.
>
> (02EL)

This gives Elgin professionals a sense of solidarity with each other against the outside world: they resented for example the cavalier way, as they saw it, in which Aberdeen-based consultants arranged their sessional visits to suit themselves rather than fitting in with local needs; they felt under-resourced in contrast to the resources which Aberdeen itself attracts; they felt their wishes and needs were not understood by central decisionmakers.

On the other hand, it meant that professionals in Elgin were thrown onto each other to a greater degree than in the other two locations simply in terms of numbers; there were far fewer professionals of each group in Elgin than elsewhere. And although attitudes to major issues did not show any marked variance in Elgin when compared to the other two locations, the feelings which were expressed about working with each other did show some differences. More concern was expressed over the calibre of colleagues (whether high or low). More reliance was placed on these factors because there were fewer ways of manoeuvring around difficult individuals since there were fewer alternative individuals occupying similar positions to whom recourse could be made. Respondents tended to talk about working with particular individuals rather than with particular professionals; they emphasised the importance of personality rather than professional skills. The district medical officer was characteristic:

> I'll repeat what I said earlier - a lot of this co-operation between authorities depends on personalities...With my previous work.... I had a very good relationship with the

> director of social work, and the architects, and the planning boys, and the sanitary inspectors, who were, I don't know, we just hit it off. I didn't have nearly as good a relationship with the director of education.... I think personalities come into it, and we've been very lucky - we've had very good personal relationships, we've never had real difficulties in that way, I think we co-operate really quite well. Certainly haven't had large numbers of complaints - angry letters from doctors or the social work department, and that's what I would have to judge it by. We have perhaps more co-operation than usual.
>
> (03EL)

This did, of course, happen in the case of respondents in Aberdeen and Glasgow, but to a lesser extent. In addition, Elgin respondents seemed to retain a greater sense of the recent history of the health and social services in the area: things were better - or worse - in the past; changes had been introduced from outside and imposed from above, to local detriment. They tended to account for present difficulties in terms of past actions.

3. Inter-professional differences

The third proposition initially put forward was that not only was there likely to be such a thing as 'the professional view' as distinct from other views and which might be modified according to location, but that different professions themselves might exhibit

modifications of 'the professional view'. Perhaps not surprisingly this proved to be the case. The literature on the sociology of the professions and on professional ideologies, as reviewed in an earlier chapter, certainly stresses differences between professions based on factors such as claims to expert knowledge and training, restricted access to professional membership and so on, which lead to differences in world views and definitions of problems and diagnoses.

One of the clearest examples of inter-professional differences was in the responses given to the question about central government's priority policies: in essence, were respondents in agreement with policies which gave priority to the dependency groups? As seen in earlier chpaters, consultants were especially lukewarm about the policies followed by ward sisters, NHS and social work managers and GPs. In contrast, district nurses, health visitors and basic grade social workers favoured them more strongly. In another example, health visitors came out as strongly supporting a reallocation of resources in favour of preventive work and health promotion; GPs and consultants were much more reluctant to see such a transfer. Within the medical field, there were a number of inter-specialty differences exhibited; most frequent was the complaint of psychiatrists that the acute specialties dominated the medical committees and had greater say in professional deliberations. But nevertheless many medical respondents from the non-acute specialties were reluctant to support any policy that would mean taking resources from the acute sector. It seems that they accepted

the leadership role of the acute sector even though they grumbled about it in practice.

Another area of questioning where differences appeared was that relating to the moral dimension. This, it will be remembered, related to the series of questions asked about respondents' attitudes towards the balance of responsibility between state, family and individual, the voluntary sector and so on. In addition, they were asked their views about the public's attitudes to these matters: did the public expect too much of state services, were people willing to take sufficient responsibility for themselves and their dependents.

As had been shown, GPs came out very strongly in favour of family rather than state responsibility. A number of them couched their views in terms of very judgemental comments about the lack of responsibility which the public exhibits for dependent relatives and the overwhelming moral responsibility that they (the public) ought to demonstrate for their relatives. These views contrasted strongly with those of basic grade social workers who felt it was a question of state responsibility or at least the responsibility of the state in partnership with families. Professional groups such as health visitors and social work managers fell midway between the two sorts of responses. In line with their views on who ought to take responsibility, most GPs felt strongly that people were not prepared to take responsibility - again in contrast to basic grade social workers who felt strongly that they were. Health visitors and

district nurses were much more mixed in their views. Consultants contrasted with their GP colleagues; those who were prepared to pass an opinion were evenly divided on the issue of who ought to take responsibility. And they held almost exactly opposite views from the GPs in their view of whether people were prepared to take responsibility or not - feeling very positively that they were.

Nearly all respondents voiced difficulties in one inter-professional relationship or another but differed according to professional group in the extent and nature of the difficulties. However there was some degree of consensus about some of the most difficult relationships. Consultants were the group cited by the greatest variety of professionals as being difficult to work with (being mentioned by social work managers, NHS managers, basic grade social workers, GPs, ward sisters). They were followed by social workers (mentioned by GPs, health visitors, district nurses, consultants). Relationships between GPs and social workers were polarised - each saying they had most difficulties with the other. The problems most often cited in this case were to do with 'professional orientation', that is, with ways of defining problems, types of diagnosis and methods of treatment or response. The other main problems were organisational: defects in the way inter-agency business was organised resulting in difficulties in contacting each other or lack of information about what each other was doing and ignorance about each others' structures. Perhaps it is worth noting that nobody voiced any complaints about working with district nurses.

It is perhaps necessary at this point to consider the nature of these inter-professional differences. Inter-professional differences cannot all be deemed to be 'ideological' *per se*. They must have characteristics which distinguish them as *ideological*. Other differences may be of different orders - pragmatic or practical, for example. Following discussion in Chapter Two, it seems that certain sets of attitudes can be termed 'ideological' if they relate to professional perspectives on the broad politico-moral domain and/or if they represent or refer to particular models of diagnosis and practice in relation to some of these perspectives. Thus within the politico-moral domain, individualist or collectivist approaches to the social ordering of the world are ideological. In relation to models of diagnosis and practice, the dichotomies of care or cure, cure or prevention, medical or psycho-social are all ideological interpretations of the world of practice. Attitudes to some of the more practical policy issues may be indirectly conditioned by these broad ideological perspectives, but it may be difficult, or impossible, to demonstrate the direct links between ideology and such attitudes.

These considerations notwithstanding, however, there is nevertheless an abundance of evidence that major differences of view emerged between professions and often in such a way as to indicate clearly defined ideological positions. The GPs' position on the moral dimension is one example; attitudes which hold social work's views and methods to be unacceptable is another - as is the obverse, voiced by social workers, that the 'medical model' of health and ill-

health is an insufficient or partial explanation of the causes of ill-health; health visitors' faith in the efficacy of preventive and promotional work is another.

But although ideological differences clearly emerge, it is also evident that other cleavages have emerged which in some instances over-ride the differences of profession and of ideology. They can be listed thus: as intra-professional, agency, organisational position, environmental and manager/practitioner factors. The next section is concerned with considering these.

B. CROSS-CUTTING FACTORS

1. Intra-professional

Even where a professional group comes out strongly in favour of one position or another, there is always a residue - sometimes large, somtimes small - which thinks differently. It might be that this internal opposition is consistent over a range of issues in which case, it could be argued, it might represent an 'alternative' professional ideology. Such an assertion is supported in the literature on professional ideology - namely, the concept of multiple ideologies existing side by side within a single profession. In the present study, for example, there are a small number of GPs who are not judgmental in their views of the public and who believe, in contrast to their colleagues, in the state's duty to provide care for its weaker members:

It's ideal if you can get a bit of both [state and family responsibility] but I mean you can't expect relatives who've got responsible jobs to care completely for their old people. Some do their very best to combine the two but I think the state has to take steps in looking after the elderly and the dependent. (09JKE)

The same GP also spoke positively about people's readiness to take responsibility generally:

[People don't expect too much] - not in this area, not here at all. In fact I would say that the patients down on the coast in Burghead are extremely caring, they really do a tremendous amount for their elderly relatives, they really are tremendous. And neighbours as well I mean, not not just relatives. There's a tremendous amount of neighbourliness too which is excellent. You know, they come in and given them meals. Neighbours are tremendous people. Really.

There is a tendency for hospital-based social workers to express different views from their community based colleagues on a range of issues; they tend to support the priority policies less strongly than their community based colleagues and none of them favoured cutting resources in the acute sector:

Resp.I would like to see [expenditure on high tech, transplants] because, I mean, I have a chap who was given a kidney the other week and it's just vital.

Int. So you're not prepared to see the acute sector lose?

Resp.No. But it's a very difficult question. (24AB)

Another hospital social worker said:

> It's easy to say yes they should stop heart transplants because I'm not needing one - but where do you draw the line? Say no to heart transplants? It's very difficult, also open heart surgery..... (21AB)

Alternatively, certain individuals may express a coherent range of views which may differ from the dominant ideology in the profession of which they are members but which may simply mark these individuals out as 'mavericks' rather than as representing a professional sub-set. In many respects, the GP quoted above differed markedly in her views about the politico-moral issues from the majority of GPs and it may be more appropriate to see her as such a maverick.

However in many cases it may be that the differences of opinion which are expressed constitute no alternative patterning; they may be random and sporadic expressions of dissension on the part of a whole series of different individuals according to the issue in question, in which case there is no question that this would constitute a coherent and alternative professional ideology or even a series of ideologically coherent, but dissident, individuals.

The existence of 'internal' alternative professional ideologies within a particular profession tends not to show up very clearly in

the pattern of responses on the big issues. Taking the moral issues as a case in point, and basic grade social workers as a particular professional group as an example, it is feasible to suggest that an alternative set of attitudes may exist - clustering around a set of values relating to the relative importance or not of collectivist as opposed to individualist positions. Over a third for instance believe it is predominantly a family's responsibility to care, although a majority believe in greater state responsibility. It might be expected that there would be some difference in attitudes about public expectations and public responsibility on the part of the pro-family respondents in contrast to those who were more pro-state.

On examination of individuals' responses, however, there is no such clear distinction. Almost the same number of respondents have pro-family beliefs as they have beliefs that the public expects too much of the services. However they are not the same individuals in each case. Just over half of those with pro-family views believe that the public expects too much; the remainder holding the latter views are in principle 'pro-state'. But these beliefs require some explanation: respondents may believe that the public expects too much in an entirely non-judgemental fashion - the services just do not exist. On the other hand, respondents may feel that the public expects too much and is unjustified in doing so from the opposite viewpoint: that they have no moral right to depend on state services and that they should be more self-reliant. Would an ideology that is pro-family be expected to hold views that judged the public harshly,

believing that they expected too much (and ought not to)? If so, just over half such respondents may have believed so, but the remainder did not.

Responses to the question about public responsibility illuminate the matter further. A strong majority of basic grade social workers believe that the public is willing to take responsibility for dependents. Only a tiny proportion of those who are both pro-family and hold views that the public expects too much also believe that the public is also unprepared to take responsibility. All the remainder believe in the public's willingness to care.

The question of an alternative ideology - relating to the range of moral issues - in this case remains open to question and in part relates to issues of methodology. Closer examination of the qualitative data suggests that the three broad questions (family/state responsibility; public expectations; public responsibility) are not sufficiently sensitive to demonstrate whether or not there are two distinct clusterings of values around the pro-state/pro-family cleavage. But there is some evidence, however, to suggest a clustering of attitudes about the need to preserve privacy and independence around pro-family views to a greater degree than the pro-state respondents. A pro-family basic grade hospital-based social worker was characteristic of these views; when asked about at what point the professional services should intervene in a case, the response was:

> I think they should be left to deteriorate....[independence] is the most important value of all.... I think a lot should be left both to the family and the individual - but I feel strongly that the individual at the end of the day should have the ultimate say. (23AB)

But the issues of privacy and independence seem to be a predominantly social work concern; pro-family respondents within other professional groups were much less concerned with these issues. So they were not values which were always associated with pro-family views right across the professional spectrum.

The study is predominantly concerned with the spread of attitudes across a wide range of professional groups; its major concerns have been to identify the boundaries of consonance and dissonance between groups rather than within groups. It is perhaps partly due to this that evidence of the existence of multiple ideologies within particular groups is not easy to identify; further probing during the interview process might have proved fruitful. The evidence which *is* available demonstrates that within every professional group, while certain distinctive patterns emerge, there is considerable variation of views on many issues; what is less clear is the extent to which there is any distinctive patterning of that variation within each group, or whether it is a random spread of views - or how far the effect in some degree is due to the existence of maverick attitudes on the part of some individuals.

2. Agency

The agency in which an individual works may exert a generalised influence on attitudes which has as much effect as the narrower affiliation of profession. Differences, then, emerge between respondents on certain issues according to whether they are based within the NHS or within local authority social work departments. Frequently, respondents bemoaned the difficulties of getting agencies to work effectively together:

> I think what is missing is more or less the pulling together of all the agencies involved. Okay, I think if you sat down with a school teacher or a doctor or a health visitor or a psychiatrist or whatever, we'll all agree, sure, we're in the same business, but in practice it's not quite the same way. (Senior social worker 04JKE)

At its most extreme it can be seen as the clash between 'the medical model' (which other NHS respondents besides doctors frequently expressed) and 'the social model' in which different beliefs about the causation of ill-health and effective curative action lead to diametrically opposed views on policy and practice. This is demonstrated in instances such as the Aberdeen GP who claimed his sole function was to cure and treat and that it was for others (notably social workers) to look after all the other (social) aspects of patients' lack of wellbeing:

> My job I feel is to diagnose and treat or provide treatment where possible..... That's what I was trained

to do, that's what I was in it to do....And I feel the rest of those services [welfare services] ought to organise around that [but] they organise things to suit themselves. (92AB)

A social worker felt that the attitudes of NHS personnel were influenced by the medical model to the extent that they did not think that it was possible for many of their patients to live in the community:

I think there are problems with people in the NHS about people [patients] who could actually live in the community but doctors and nurses don't see that, it's not their job to see that .... but we've not got the power to say that we would like to support them within the community... because we've got very little power within the health service setting. (11DW)

Other manifestations of hostility between the two agencies were expressions of annoyance about the way the other agency was organised. Another GP said:

As far as I'm concerned the social work department is a dead loss... I've told them so on occasions and been a bit unpopular as a result....we've been trying to look to them more, recently, but if we refer somebody to the social work department nothing much seems to happen. (91AB)

Similar hostility was expressed by an orthopaedic consultant:

The social work department has outgrown its strength; it just doesn't know what it's there for at times, and tends

to interfere. When the social work department is asked for help you'll get it if they're allowed to hold a case conference about it. They apparently can't do anything without a case conference. And they waste time. In my view, the social work department is grossly over-funded and if it's the care of the disabled and care of the deprived that we're interested in, then the sooner it's taken out of the hands of that sort of mechanism the better. (44JK)

A basic grade social worker spoke in sorrow rather than anger:

> The sort of structures we work in create these [inter-agency, problematic] situations and so I'm not surprised....I think the sort of demands that are placed on the individual social worker end up really placing constraints even on the way you view your work...we think within the structure that we work in and we are very insular I would say in the way we function....that's certainly what tends to happen and on the interface between different agencies that's very much what happens, we retrench within our own structure. (21JK)

Another example might be the frequently heard dismissal by social workers of the nursing and medical role in the care of mentally handicapped people. A typical social work comment in response to a question about NHS involvement in community provision was:

> I don't know what that means because the NHS interpret that as setting up a clinic somewhere with doctors and

nurses and it becomes a mini-hospital again. (29JK)

Differences in perspective lead to differences in terminology and usage. NHS staff, for example, were less precise in their usage of the term community care, seeing it broadly as the distinction between hospital and non-hospital care. Local authority social work staff were much more careful to limit it to care either in one's own home or in hostels/group homes and the like. Even the distinction between the term patient and client tended to be agency-bound; NHS staff employing the former and social work staff using the latter - although use of the term client has begun to spread across the boundaries being adopted by the professional grouping perhaps mostly closely resembling social work within the health field: health visitors.

But where the similarities are close, the perceived differences get bitter. Territory is in dispute and professional futures may be threatened. Health visitors and social workers are perhaps the two groups which are in greatest contention with each other. They tread the common ground with difficulty as is demonstrated by the number of instances of problems reported between each other. On the one hand they register similarity of view on many issues especially when health visitors, for example, are compared with their other nursing colleagues - for instance, on the matter of family or state responsibility they resemble social workers more closely than either district nurses or ward sisters. Similarly, the views of the two groups with regard to a belief in the need for more resources for prevention are closer to each other than to almost any other group.

But in spite of these views in common, each registers disquiet about the other. Social workers feel that health visitors are trying to do their jobs and health visitors see social workers as uncooperative and differing in 'philosophy' from them. A health visitor speaking about the social work approach said:

> I think they have different priorities because simply because of the nature of their work and the nature of our work they are bound to have conflicting, we're bound to have conflicting priorities. They deal with things, they try to deal with things from a social and welfare rights point of view. And sometimes social and welfare rights can clash with health..... we are health, health, health and social aspects come in as a side. (21JK)

While the difference between the health visitors and social workers can be seen as an inter-*professional* difference, it can also be seen as an inter-*agency* one. Health visitors, in this sense, can be seen as the 'rubbing edge' of the NHS, that component of the health service which has closest affinities to the oppositie agency but is not part of that other agency. Health visitors may be 'social workers' to their medical colleagues but they are health workers (and thus dominated by the 'medical model') in they eyes of social workers themselves.

In addition, philosophical or definitional differences may be compounded by organisational differences; boundaries segregating

one professional grouping from another are accentuated by different decision-making processes, differences in accountability, budgetary procedures, physical location and so on. If a nurse manager, for example, cannot get hold of a social worker at 9 o'clock in the morning on the telephone and is not given any means of contact at a later time, already existing differences of viewpoint will be heightened by frustration. There are frequent complaints about the hierarchies of decision-making in each others' organisations. Decisions which impinge on the ability to establish effective collaborative relationships cannot be made at grassroots level but have to be taken back up the line to be decided upon by more senior managers.

3. Environmental

Another cross-cutting or mediating factor is the location where a respondent is placed - and this means, principally, the distinction between whether or not the respondent is based in the community or in a hospital or in the main offices of the bureaucracy (for example, health board headquarters). In particular are the differences in views between hospital-based ward sisters and other nurses (district nurses and health visitors, both of whom are community based) and differences between hospital doctors and their colleagues in the community, the GPs.

Ward sisters and hospital doctors, for example, are a lot less firm in their support for central government's priority policies than other respondents. In contrast, GPs favour the policies more than hospital doctors, although less so than community-based nurses. There is no doubt that being based 'out there' in the community gives staff a particular perspective on the needs of people dependent on community care services. This informs their views on the relative balance between family and state responsibility. Health visitors and social workers (although hostile to each other in certain situations) are like-minded in the importance they place on state responsibility - especially in contrast to ward sisters who are almost as judgemental as GPs. GPs, however, do not follow the 'community based' perspective in the matters of the moral issues.

Health visitors, district nurses and social workers all see themselves as overworked and oppressed by the size of their caseloads. They see this work burden as the outcome of their agencies' and central government's reluctance to give real priority to community-based work. The direct experience of the reality and extent of people's dependency on the statutorily-provided services in the community and the pressures this creates for staff is different from an office-bound manager's direct experience of having to make choices about the allocation of resources between competing demand - and perhaps different, too, from the experience which hospital-based professionals have of 'the public as patient'. When such professionals see their patients, they are removed from the daily reality of life in the community; patients, in some senses, are

divested of their usual social personnae once they enter the total institution of the hospital.

4. Organisational position

It is clear that the level at which a respondent is located in his or her agency gives a particular perspective on policy issues; and this may inform a respondent's view on the moral issues too. Organisational position is relevant in two respects: first, it determines the extent of direct responsibility or involvement which an individual has vis a vis a particular issue, how much decision-making power s/he has and for how much s/he is accountable in terms of outcomes. Secondly, it determines the extent and type of knowledge a respondent has about those issues. That is not to say that the higher up the hierarchy an individual is placed, the greater and more all-encompassing the knowledge may be. Rather, the content of it will alter.

The front-line (bottom level) field worker has a detailed knowledge of the daily burden faced by care-givers; of the fragmented and uncoordinated nature of the services provided; of the lack or inappropriateness of services; of difficulties in collaborating across professional or agency boundaries. But at the same time, that fieldworker will have little knowledge or understanding of the pressures faced by managers to balance budgets, impose cuts,

reallocate resources from one area of the service to another. Frequently, the field worker has very negative views of management:

> I feel I have very little connection with district management at all. The only contact I have with them would be if as a group we were making demands for resources..... Frequently we're given that kind of dictum without any extra resources or any particular strategy for applying it, so again pretty negative.
>
> (Basic grade social worker 21JK)

And the same is true in reverse. The manager will have only a limited perception of the reality of service delivery and of the experience of those using the services - although this may of course be mediated by personal experience as demonstrated by some responses.

Community-based fieldworkers (health visitors and social workers) for example are more wholehearted in their support for the priority policies than their managers and this may well be related to the fact that they do not have to translate the policy into action. The more senior the manager, the more equivocal the response in relation to the priority policies. The senior manager is exactly the officer faced with the hard task of translating exhortatory policy guidelines into a practical plan of action. The respondent at the lowest level of the organisation sees the consequences of management equivocation and compromise, and interprets it as a failure in implementation without being aware of the competing demands being made upon senior managers.

Respondents at these lower levels, although feeling strongly about certain policies, nevertheless feel powerless to influence what their organisation decides. Not surprisingly, the more senior the individual is, the more s/he feels able to influence (or decide) the organisation's policy (i.e. what the organisation does; *broad* policy is formally set by lay members of the Board or the Authority in conjunction with guidelines set by central government). But those senior managers are at the same time those who feel equivocal about that broad policy.

In terms of the moral issues, senior managers in both agencies are far more sympathetic to the public than are their juniors. They see care for dependent people as predominantly a state responsibility - perhaps because the service for which they are responsible is precisely the expression of that state responsibility. But more particularly they contrast with lower level staff in their views of public expectations of the services and public willingness to take responsibility. This may reflect the greater knowledge that lower level staff have about those members of the public who are in receipt of services or who are demanding services which may not be available. Placed at the front line, such staff often have difficulties in their dealings with difficult and demanding patients or clients. They may become jaundiced in their views of the public; they may grow resentful of what they may define as constant and unjustified demands on the state services. The health visitor who expressed an understanding of people's problems and believed that more help should be provided:

> I think we've fallen badly behind, I just don't think we're moving towards the future....these people who are elderly, have worked all their lives, they have contributed towards society - then they should get [something in return] - when I get to that age I'm going to expect something..... (20JK)

But she also held rather mixed views about the public in general:

> They do an awful lot of taking and not a lot of giving I'm afraid..... they don't want to take responsibility for themselves.

Their managers however do not see this side of public demand and are cushioned from it; their views of the public are conditioned by their lack of direct knowledge just as their juniors are affected by over-familiarity. An area social work officer spoke very positively:

> Yes I think so [the public is prepared to take responsibility]. I think they are, after it's explained to them and perhaps given extra counselling and support and perhaps the assistance of a home help or other service that can maintain a person and sometimes that's all that's missing and the public go away quite happy. (16DW)

Nevertheless, managers sometimes also have unrealistically high expectations of the public, believing that they can cope more easily than is really possible. Many of them cite people in India or in Singapore or other parts of the world as providing good examples:

> I would like to see a lot more help given to relatives who do look after their own people and we need to educate

perhaps even at school our children, that this is the commitment they have. You go out to Singapore as I have and you never see an old people's home out there. All the elderly are looked upon with much more respect; they are not cast aside and we've got a lot to learn.

(Senior nursing officer 19JK)

5. *The manager/practitioner distinction*

The distinction between senior and junior within the organisation is overlaid by the manager/practitioner distinction. Front-line workers are distinguished by two characteristics: one, they tend to be junior people in the hierarchy of their organisation and two, they are practitioners as opposed to being managers. Doctors, of course, are an exception; either, as GPs, they are independent contractors and remain outside any large organisational hierarchy, or as consultants they may be part of a medical but not a managerial/bureaucratic hierarchy. In all cases they retain high status. Other practitioners, however, cease to be practitioners as they rise in status within their organisations; they become managers. How much they retain the ideologies and behaviours of practice and how much they take on new patterns (and at what stage) is a matter for empirical investigation.

The nature of the managerial experience as contrasted with that of the practitioner is relevant in a number of instances. The most fundamental distinction centres on the tension between a

respondent's professional autonomy - 'clinical judgement' as it is referred to in the medical profession, but also claimed by other health workers and social workers - and a manager's need to be managerially responsible for service provision which is delivered by those 'autonomous' professionals. This is frequently reflected in responses to questions about inter-professional working. NHS managers found they had most problems in dealing with consultants. Consultants did not rate managers themselves as being difficult to deal with but they registered annoyance with the health board itself or with higher levels of the NHS:

> When decision-making was taken out of the hands of the medics quite deliberately by the reorganisation in the NHS we were left with very little influence .....a lot of decision-making is too diffuse and it's not necessarily being done in the open. (Orthopaedic surgeon 17DW)

And although they did not rate managers as difficult, they said they felt they had little influence on what went on in their organisation (while managers constantly complained that consultants were a law unto themselves and made policy implementation exceedingly difficult as a result). This one-sided view of a problematic relationship is paralleled in health visitors' and district nurses' views of relationships with GPs as being difficult. GPs on the other hand saw no difficulties in their relationships with the community nurses.

In matters which were perceived to be the responsibility of managers, practitioners readily agreed that they (the managers)

could improve performance - in such matters as making better use of resources, especially by cutting down on administrative costs. Managers, of course, disagreed. Definitions of the sorts of constraints which respondents worked under tended to vary along the manager/practitioner divide. Practitioners saw themselves as constantly under pressure and overworked. They saw workload and staff shortage as being major problems. Managers on the other hand were much more concerned with issues such as the scarcity of resources and the implications of cuts in resources. In addition, managers were much more wary of the voluntary sector than practitioners who in general viewed it favourably. It may be that in responding to questions about voluntary involvement, practitioners were thinking about the principle of voluntary action while managers were thinking about the practical implications of voluntary action on their own plans and efforts. Certainly, in the case of NHS managers, worries about the distorting effects of voluntary fundraising on annual plans was a factor.

C. DISCUSSION

The different professional groupings depicted in the earlier part of this chapter exhibit distinctive attitudes in relation to a number of key issues. District nurses, for example, can be seen as different from health visitors; social workers differ sharply from GPs and so on. But the picture is more complicated than that.

For every set of possible responses to a particular issue, each group registers a range of replies. It may often be that some clear patterning of response emerges according to professional grouping - to an extent that something which might be called 'professional ideology' can be identified. But there is always variation in response within the professional group in question and other attributes besides profession seem to be significant according to context or issue.

However, this interweaving and overlaying of cross-cutting factors operates to obfuscate patterns of distinctiveness and it is only by careful examination of the responses, by going back to the original data, that understanding can be reached of the manner in which one intervening factor mediates in favour of or against another. The example, perhaps, of social work is apposite. If there is such a thing as a professional position, or a professional ideology, which characterises social workers and which stresses the importance of state responsibility in the provision of care it is also one that stresses the values of individualism, in terms of privacy and independence. Thus within the profession there are competing ideological impulses, many of which will be echoed in the responses given by other professional groups. Further, in some respects similarities between field social workers and other front-line practitioners may be greater than those between field social workers and their managers (who are members of the social work profession). Fieldworkers' strong approval of the priority policies is a good example. In other cases, the major difference might be along agency

lines - NHS respondents having one general view about the definition of community care and social work personnel having another.

Thus significant divisions amongst respondents occur which are context and issue specific. Respondents group around different responses according to the variety of cross-cutting factors discussed earlier. But there is one explanatory principle which has not so far been considered: that is, that respondents are indeed conditioned by the influences of professional and agency allegiance, by their organisational position and by the character of their work and that these operate differentially according to the issue. But permeating this is the importance of how relevant the issue is to any particular respondent. Some may argue at the level of high principle but without detailed knowledge; others may be so deeply enmeshed in the detailed knowledge that they cannot draw out issues of principle. Some may be willing to discuss issues at the abstract level; others may only feel competent to comment if they have concrete experience. Degrees of experience, abstract or concrete, may affect the nature of responses. In addition, some may have little knowledge and argue from lay - and 'prejudiced' - perspectives. And yet others may feel unable to answer out of ignorance.

Issues of pertinence and relevance, of the abstract or the concrete, of beliefs and assumptions are clearly all bound up in the patterning of professional views. Whether they can be accounted for

in any more organised or coherent a fashion than merely stressing the inchoateness of this variety of response will be considered in the following chapter.

CHAPTER SEVEN

BEYOND IDEOLOGY: BELIEF, CULTURE AND CIRCUMSTANCE

It has become clear from the discussion in Chapter Six that the impact of professional ideology - or 'belief' - is considerable in respect of attitudes about a number of policy issues, particularly those in the politico-moral domain. But it was also suggested that a number of other factors cut across this impact - to do with the effects of competing environmental or practical influences on the particular professionals involved. How, then, is sense to be made of this complex pattern of interaction?

It is apposite at this point, perhaps, to return to the theoretical considerations discussed earlier in the thesis and to examine their utility in any attempt to explain such interaction. Pluralist interpretations of organisational behaviour, within a broadly phenomenological perspective, which acknowledge the interplay of competing interests - sometimes joining in coalition, at other times in contest - were held to be most useful. Within this framework, the role of professional groups and individual professional practitioners was seen to be highly influential. Professionals were able to exercise influence and power through their status and 'expert knowledge'; through their control over resources - especially at 'street level'; and through their ability to define needs and problems and their solution.

Professionals, however, were not seen as a homogeneous group. They were distinguished from each other by membership of particular professions. The distinctiveness of one profession from another was both demonstrated *and* maintained, in part, through the medium of professional ideology. But professional ideologies were high-level, abstract constructs; 'operational philosophies' were the means whereby ideologies were translated into frameworks for everyday action. Even so, commentators found a disparity between ideological position (even though translated into operational philosophy) and everyday reality. The construct of the 'situated account' was introduced to explain how professionals came to terms with discrepancies between what they did and what they perceived and said. The 'exigencies of practice' and the deviations from operational philosophies which they created seemed to intrude with some regularity into many sociological analyses.

It seems that the distinction between the high-level and abstract construct of ideology (with its lower-level partner, operational philosophy) and the concrete reality of the situated account can usefully be applied to the interaction of cross-cutting factors described in this interview study. But the argument in this chapter will go somewhat further. It will agree that the distinction between the abstract and the concrete is of fundamental importance, but it will argue that there is another construct that partially overlays them both.

A threefold framework

Intervening between and across ideology (or beliefs), on the one hand, and reality (or the circumstance of everyday action), on the other, is, I shall argue, 'culture' (or, even, 'tribalism'). It may be *professional* culture or *organisational* culture; it is different from ideology in that it consists of sets of attitudes founded less on coherent (and arguably internally logical) patterns of beliefs and more on assumption, stereotype and long-term custom and practice. Ideologies are sets of beliefs which offer explanations of the world to those individuals holding those beliefs; they represent theories about the social and (especially in the field of health and health beliefs) the physical world. And as discussed previously, and because they represent logically integrated explanatory theories, they provide 'morally charged mandates for action'. Culture, as employed here, on the other hand, is about demarcation; it is both inclusive and excluding (hence the appropriateness of the term 'tribal'). It separates those within its boundaries from those without. Further, it is 'emblematic' in the sense that members of the group are seen to possess certain common attributes (of character, behaviour, appearance and so on) which outsiders do not - and vice versa: outsiders possess certain other attributes (usually less appealing) which group members do not.

It is not an entirely new construct in the sociological analysis of the professions or occupations (and it is frequently used in a more general way in much of the management literature - Handy (1983) is

one such example). Huntington (1981), in an example from sociology, organises most of her data on the occupations of social work and general practice around the notion of 'occupational culture'; several sources talk about the socialisation (Bucher and Stelling, 1977) or the acculturation (Dingwall, 1977) of entrants into professional groups during the training process through which they acquire the cultural trappings which mark out group membership.

Part of these cultural trappings are the stereotypes and assumptions which Bruce (1980), for example, describes as significant in influencing professional behaviour. Following Krech and Crutchfield (1958) he says that a stereotype can be both a sociological concept (where it is a belief or attitude widespread in society - and by implication a mistaken belief) and a psychological concept (where it is a belief or attitude about an object that is so over-simplified as to fail to recognise the 'true' attributes of the object observed). He cites Gardner Murphy's (1953) observation that sterotyped views contribute to the building of group solidarity. Bruce stresses that a consequence of the prevalence of stereotypical views is that value judgements about groups other than one's own tend to be based on inaccurate information.

Dingwall (1977) also makes the same point. Stereotyped assumptions about other groups are transmitted within the group through its 'oral culture'; new recruits must master this 'oral culture' in order to demonstrate 'competent membership' of the group. He describes some of the stereotypes held by health visitors - of hospitals and hospital

nurses and of social workers in particular. Another feature of this oral culture is the telling of 'atrocity stories', at the expense of other professional groups and usually based on inaccurate or false information. This performs a similar function as that of the stereotype: it is a form of group self-defence, protecting and building group solidarity, especially when the group in question is less powerful than or under threat from the other.

But most sources do not make the distinction which will be made in this thesis between ideological beliefs (where difference is an incidental outcome) on the one hand and the boundary-drawing components of culture (where difference is a purposive and intentional outcome) on the other. Huntington, for instance, uses 'occupational culture' as an all-inclusive category of which ideology is a part. For her, occupational culture comprises the whole ordering of inter-professional differences: these include differences in mission, aims and tasks; focus and orientation; knowledge; technology and technique; language and terminology; ideology or 'dominant value orientations'; identity; and status and prestige. Ideology for her is a part of culture rather than a separate analytical category or construct.

But in the present analysis, it is proposed that ideology and culture are distinct and independent categories. A third category which interacts with the first two, is that of circumstance. As Stoll (1976) suggests, ideological attitudes may not be a good predictor of behaviour for a variety of reasons - there may be several different ways to implement ideology; other, more powerful and/or more senior,

individuals may be the final arbiters of decision-making; there may be insufficient resources for adequate implementation. Similarly, entrenched positions, dictated by professional or organisational culture, may not be carried over into practice. Circumstances, in all their variety, may intervene and exert powerful constraints - or imperatives - on behaviour. These are Hardiker's 'exigencies of practice'; they go to make up the context of Smith's 'situated accounts'.

It is argued here, then, that the interplay of beliefs, culture and circumstance provide the milieu in which professionals in organisations have to make decisions and engage in the business of professional practice on a daily basis. It is suggested that the cross-cutting factors, identified in Chapter Six as all being part of the complex of influence bearing on the content of professional attitudes revealed in the interview study, can be set satisfactorily into this threefold framework. The second half of this chapter will explore this using evidence from the interviews.

At this point, it is perhaps timely to note that research based solely on interviews has one major limitation: although it can establish respondents' subjective views about the work they do and the relationships they establish with colleagues within and outside their own profesional group, there is no mean of establishing how accurate the picture they portray really is. So the findings presented in this thesis make no claim to represent 'objective reality'. They are a record of respondents' perceptions about the way they work and the

things they think and believe. It has to be accepted on the basis of evidence from elsewhere rather than from within the study itself that the patterning of their perceptions is a significant factor in the manner of their behaviour.

That said - and accepted -, then, the importance of a study which seeks to develop an understanding of the organisation of attitudes is twofold: it is important because such attitudes affect organisational behaviour and the implementation of policy; and it is also important in an epistemological sense. It contributes towards our understanding of the nature and properties of professional attitudes against the broader backdrop of the sociology of the professions.

THE INTERVIEW EVIDENCE

Although the present study cannot provide direct evidence about the content and manner of professional behaviour and the existence of inter-group contrasts, there is external evidence to show that inter-professional differences are widespread. Much of this derives from studies of attitudes and ideologies, as discussed in earlier chapters; but other evidence comes from empirical studies of interprofessional working, such as studies of the primary health care team (Lonsdale *et al*, 1980, McClure, 1984, Bond *et al*, 1986), which show that in spite of official exhortations to the contrary (DHSS, 1987), teamwork involving several professional groups is beset with problems and lack of success.

Such research shows that the encounter in the arena of daily work is characterised by sometimes extreme differences in outlook amongst the various groups of professionals involved. The present study is no exception; a majority of respondents report such differences in their relationships with other professional groups. It is worth, therefore, looking briefly at some of these reports in order to examine some of the reasons respondents themselves give for the existence of these differences. The rest of this chapter will be concerned with looking at how far, in effect, do the ways in which professionals themselves account for their differing attitudes and perspectives correspond with the classifications which sociologists employ - especially in relation to the concept of ideology. It will then go on to argue that the ideological explanation alone is insufficent and will consider the relevance of the notions of culture and circumstance.

Inter-professional working

The most numerous instances of incompatibility in working together arose between GPs and social workers; but there were many other difficulties recorded, between social workers and health visitors, between health visitors and GPs, between GPs and hospital consultants and between hospital based social workers and consultants.

Difficulties were expressed in both the practical terms of organisational and structural issues and the abstract terms of orientation and attitudes - and also in terms of 'individual personality'. For instance, one GP found difficulties in working with social workers because of the way their work was organised:

> I think again one of the difficulties is that the way the social work teams are arranged - one of them has a particular responsibility for the elderly, one for the handicapped, one for children, so that again tends to cut across what we do. (94AB)

Another GP referred to the competition between medicine and social work in the definition of problems:

> doctors and social workers - again you vie for whether a problem is a social or a medical problem ... to establish precedence there. (13JB)

In the case of a district nurse, difficulties in working with both GPs and social workers were described:

> I feel it very much.....it's very frustrating...You're a buffer in the fact that you've got the doctor you liaise with, she comes back and says I want this that and the other, you go to the social work department and get nothing from them. And I feel, well, you know, I thought it was teamwork and here's me going in, and I just felt nothing was being done. (14JKE)

Another district nurse expressed resentment of some GPs:

> I think some GPs will tend to, what shall I say, throw all the dregs of the day at you.....if the

> GP is not very helpful at, say, getting the geriatrician out, then you're left with it to do. (15JK)

In the case of social workers, hostility towards health visitors was sometimes expressed by them in terms of differences in fundamental attitudes:

> Yes, I think there is a difference between our attitudes certainly, from our experience with health visitors. And their whole training has been to take a person into care and to - in many ways take away their rights, I suppose - and our training leans to the opposite point of view almost - and I think there is some kind of friction in our attitudes on many points. (06AB)

Similar hostility was felt by some social workers towards GPs:

> I think that there certainly is a lack of understanding by a large number of GPs of the social work role. It's a suspicion and it's also at its worst [because they think] that if they do begin to develop a relationship then there's a floodgate opening .... that's again to do with the structure and the pressure they can be under as much as any real recalcitrance. (21JK)

In many cases, the importance of personality was stressed. Whether relationships between professions or agencies were good or bad often depended, they felt, on the individual personalities involved. A sector administrator, for example, talking about relationships with other professionals said:

> You couldn't say that we have a better relationship with one organisation rather than another because of that organisation per se - a lot depends on personalities...if there are - taking social workers for example - if you can relate to, or you get on with someone in the social work department, you're more liable to communicate better with them, or pick up the phone and ask them about something than if there's someone you don't particularly like on a personal level. And I think it's this - human relationship thing. (01JK)

A social work manager believed that personalities caused many of the problems experienced between social work and the health service:

> Maybe it [difference of opinion] does to a wee extent [cause obstruction], but I think it's personalities in that case that's the greatest obstruction. (29AB)

A divisional nursing officer was of the same view:

> I think probably it is personalities really, more than lines of communication. (17JK)

Evidence such as this, then, demonstrates a widespread sense of discontent with regard to the success of inter-professional working. Explanations of the failure to collaborate successfully is put down both to structural difficulties - the way the services operate, differences in organisation, lack of understanding about the pressures under which colleagues in different professions have to work and so on - , to personality differences or (where cooperation is good, to affinities) and, especially, to differences in approach and orientation (or what might be termed ideology).

Just as academic analysts have identified 'professional ideology' as a barrier to co-operation, so practitioners recognise the same constraints. A social worker, talking about health visitors, for example, described them as adopting a medical view of old people's needs for care in contrast to their (social work) views:

> these people [old people] don't want - they want to go back to their independence - it's the health visitor's anxiety coming through, and not the person's, you know the old folk. And that is unethical..... And very often they see it purely from a medical point of view and not - they don't consider the emotional stress. (06AB)

A senior social worker, who led a team working exclusively in a primary care setting, in a health centre with attachments to a number of group practices, expressed her disappointment at their failure to establish successful inter-professional working:

> I have felt disappointed in the level of co-ordination - you know, I feel that things should be better co-ordinated in a primary care team, and that patient management ought to be optimum - but I mean, dreadful things happen - and people fall between, even where there's a nurse, a health visitor, a doctor and a social worker. And everybody is assuming that somebody else is doing it..... I think professional orientation [causes it]. Partly the problem that health visitors and nurses feel they can do nothing without asking the doctor. (10AB)

Ideology was not the only explanation; they also saw it in terms of organisational and personality constraints. These are not unlike

the sociological explanations relating to the 'exigencies of practice'.

The role of professional ideology

Practitioners may ***believe*** and report that they view things differently according to which professional group they belong; and it has been shown above that this perception of difference is revealed in discussion of experiences of inter-professional working. Professionals regard it as a significant factor in the creation of problems. But do such ideological differences exist independently - that is, separately from professionals simply saying that they do? Analysis of responses in earlier chapters of this thesis suggested that they do (although, as has been argued, cross-cut by other factors). It was possible to demonstrate that differing attitudes on a number of issues characterised different professional groups.

Broadly speaking, ideological responses were deemed to be those relating to issues in the politico-moral domain (the relative responsibilities of family, individual and the state; the role of voluntarism and so on); to views of the world specifically as they relate to professional practice; and, perhaps, to modes of organisational behaviour - the 'bureaucratic' (managerial), the 'professional' (practitioner).

Taking the politico-moral domain as an example, it is clear that when responses on those issues are examined, significant differences

between professional groups emerge. Most striking was the contrast between GPs and many of the other groups in respect of their views about the question of responsibility. A solid majority of GPs felt it was predominantly the responsibility of families to care for dependent members as opposed to a minority of social workers and only half of health visitors. In contrast, most social workers felt it was a matter of state responsibility or joint responisbility between the state and families as did almost half the health visitors and social work and NHS managers. District nurses, however, were more like GPs though a little less overwhelmingly taking up the 'family responsibility' position.

The following remarks of one GP were characteristic of many:

> Morally it should be the family [taking responsibility] but then we're not living in a very moral age. And the families just don't want to know - the hard fact is that people really don't want to have this burden. (18JB)

Another GP voiced similar views:

> I would like to see much more family responsibility but modern society has drift away from it and there's nothing really that medical people can do about it unless the society as a whole accepts the need for, morally accepts the need for, care by the family. (91AB)

A majority of district nurses mirrored this view:

> I see it in this country the way we run things, then I see it's got to be the family has the prime responsibility ... often the family should and could help a lot more - because it's their folks, they should have a responsibility to their own people. (15JK)

Social workers, on the other hand, viewed things rather differently:

> Well I think we live in a society which has admitted by stating it's a democracy... that the community is responsible for the community.. well, actually, well the state, I think I have to say the community and the state. (10DW)

and

> It comes back to the question of what is community care. You know, because can the community care for the family as a whole? Maybe the family needs to be cared for by the community and that would include any relatives with particular problems. I certainly, I think , I don't think I would go along with the argument that the family ought to care and that's all there is to it .... no, I think certainly the state ought to care... has a responsibility to see that.. the dependency groups, to see that they are being cared for. (05JKE)

Health visitors spoke in a similar vein:

> I have great sympathy for relatives. I think it should be a state responsibility. Um, it would be nice to see

relatives getting more involved with the elderly - er - but it can be very difficult for them. They can be made to feel very guilty if they don't look after their relatives.(06JKE)

Perceptions about the public tended to match views about the issue of responsibility. Those who believed it was a family responsibility to care tended also to believe that the public in general was reluctant to care and that too much was expected of professionally provided services. A number of GPs were very judgemental in their views of the public:

> I would say the majority [of the public] opt out. Fewer and fewer folk are going to upset their own lives at all to cope with their own relatives. I think they're being selfish and not accepting of the position.
>
> (92AB)

and

> To get a family to care for an elderly relative they have to be, have affection for that relative, they have to understand the problems, they have to care about people in general and.... they don't. That's a bit general, but people are too involved with what they want to get out of life.... I think they should take a greater responsibility.
>
> (20DW)

and

> I do blame the old people themselves .... because they voted for this system .... and they have done nothing to change it ... they have sat expecting me and the nurse and

> everybody else to supply what they want ... until they die. I do blame them and ... as a GP what I do notice is that the old people of 70 and 80 today are not the same as old people when I started out ... they're two different breeds ... the present lot expect to be kept as 60 year olds forever. (92AB)

But those who saw a greater responsibility lying with the state, tended also at the same time to be less judgemental of the public. They were more ready to see the strain and stress that is often involved in caring for a dependent relative and felt that the public had the right to expect more from the services. A social worker said:

> I think they [the public] should expect more if they want it..... I think they are willing [to care] in the sense that they want to but sometimes - it's usually the partner you know, if it's something like the mother's mother then it's usually the husband so they have torn loyalties between the two. (04DW)

and another social worker:

> I find the majority of them are [willing to care], it's surprising the amount of wives, spouses, that accept the nature of their spouses' illness - mental or whatever ... and stand by them. (05DW)

Some health visitors felt similarly:

> I don't think so [that people expect too much of the services], I feel that the people I've come across who

have some quite hard jobs with elderly relatives, I think actually sometimes put up with quite a lot more than perhaps I would expect to myself ..... yes, I think the majority of them are [willing to care]. I mean, saying that, I have come across people who just don't want to know at all. But again, few and far between. (27JK)

Fewer district nurses were so sympathetic although a number were:

There's always the minority that'll always want more but to be truthful the majority of patients are very grateful, they think they're getting a lot..... there's always the majority we feel that are willing to take responsibility ... as long as they're getting that wee bit of support from the backup services. (15JB)

Most were more sceptical about the public though:

they're liable to say "Oh get the nurse in, you should have a nurse to do that." I think people become selfish - they don't realise just how many dependent people there are..... Nowadays a number of them are not [prepared to care] - people are too busy with their own lives now. (17JB)

As noted earlier, ideology can be defined as a patterning of beliefs and values relating to views about the ordering of the world at relatively high levels of abstraction; and within that, *professional* ideology is that which underpins world views insofar as they relate to professional practice. The views expressed here about the politico-moral issues of social responsibility fall into this

category. On evidence such as this, it seems that clear ideological differences emerge on these issues between some groups of 'front-line' practitioners located in both the health and social services. At one extreme are the GPs who hold strong and judgemental views about the moral responsibility of families to care; at the other extreme are social workers who have a more open view about the moral position: the state has an underlying responsibility, although families also have a role. They tend not to 'judge' the public by perceiving it as morally deficient in failing to accept responsibility. Located somewhere midway between the two are health visitors and district nurses.

It seems clear, then, that not only do professionals *believe* that they differ amongst themselves on ideological grounds, but that they really do, in fact, hold sets of beliefs which distinguish one group from another. But ideological distinctiveness is not the only significant factor in the analysis of professional attitudes; other factors are also important.

Force of circumstance: the conditioning of everyday action

As has been shown, the investigation of attitudes in the politico-moral domain reveals the existence of clear ideological differences between professional groups. This confirms the findings of other research studies and it also confirms the views of practitioners themselves; as discussed above, they tend to account for failures in

inter-professional working in terms of fundamental differences in attitudes.

But further investigation of respondents' attitudes demonstrates a degree of *similarity* in views on some issues. This is often most clearly revealed when their views are set against the views of other categories of respondents - managers and hospital-based staff, for example. Managers in both the health and social services, for example, frequently showed a greater empathy for the public than the community-based front-line practitioners who, in fact, had the greatest contact with them. In spite of ideological contrasts between, say, general practitioners and social workers, or health visitors and social workers, these were frequently cross-cut by contrasts between all of them on the one hand and managers, removed from the field, on the other.

Thus managers could express positive feelings towards the public untempered by direct knowledge of the reality of the circumstances - both the difficulties faced by, and created by, the public and the heavy strain placed on some field staff by those difficulties. Field staff were often torn between feeling sympathy for their clients but also frustrated and pressured by them. A sector administrator, for example, recognised that he did not have direct experience of the problems:

> As I say, not coming directly in contact with a lot of them, but I do obviously speak a lot to nursing officers

and medical people ... but you do hear of families doing this and that .... and who do realise that they have a role to play. (11JB)

This respondent thought highly of the public but tended to be critical of some practitioners. He recounted a case where a family had requested the use of a particular sort of bed - in his view, legitimately - but the nurse involved had felt them to be too demanding; he was also critical of GPs, suggesting they did too little for dependent people:

> I think it's a pity. I think the GP was and should be somebody who is held in high esteem by the population. And I think services provided by us in the community would seem so much better if the GP was generally accepted as being the man that they admired and would come at a call. I know that they've got limited resources, that they've got limited time, but there is no doubt that the GP of today does not put the work into the job or the time. (11JB)

In contrast, however, were the views of practitioners who held more jaundiced views of the public. A health visitor, for example, said:

> I think it's because the great wave of unemployment and whatnot has tended - I'm talking about the people in this area , not about the people outwith it, but in this area the dependency on state aid is vast and they do an awful lot of taking and not a lot of giving, I'm afraid....They don't want to take responsibility for themselves. Not here. My caseload is made up of people who have not taken

> responsibility for their own lives, therefore that's why they have, they run into social problems, because they don't think. (20JK)

And yet this was a respondent who believed firmly that the state was responsible for providing care and support to those who were dependent.

In respect of issues which were the direct concern of managers and more removed from field staff - issues of resource allocation and strategic policy, for example - front-line practitioners tended to be able to offer answers directly, while managers responded in a much more circumscribed way. For them, the dilemmas were real, for practitioners, the problem of decision-making in these matters was hypothetical and therefore less charged with complexity. On the question of support for central government's priority policies (favouring the priority groups over the acute sector), front-line practitioners were more firmly in support than their managers who, while coming out in support, were much more equivocal in their responses. An NHS manager, for example, supported the policies in principle:

> Yes, I'd agree with that policy provided that you have to have - you still have to have acute medical, sufficient acute medical services so that they can cope with the needs of the community.... I mean, it's said in Glasgow that there are too many acute beds, too many acute medical wards and that this should be run down a bit to make priority for these dependency groups. All I know is that every winter,

> it's the same story. Every hospital has difficulty in finding a bed to take people into. (06JB)

But a front-line worker, a social worker, answered much more directly:

> Yes, I think we have a responsibility to cater for the disabled... the elderly, the chronically sick, the people who do require additional support and services... Old age is something that happens, chronic, mental or physical disability, these are things over which people have very marginal control.... we should spend a good percentage of our time concentrating on those people..... Mine happens to be a very personalised view because I work in this field. (08DW)

The evidence seems to suggest, then, that although professional ideology is a strong and binding influence in contributing to group identity, the factor of circumstance is also at work, cutting across ideological ties. The experience of working at the front-line, at the interface between the public as clients and the services, confers a commonality of attitudes about certain issues amongst practitioners, just as the responsibility of managerial decision-making binds managers together in their views irrespective of their agency or professional background. This is strongly reminiscent of Hardiker's 'exigencies of practice' and the backdrop against which Smith's 'situated account' is set.

Tribal ties: the strength of cultural allegiances

Individuals belonging to the same professional group exhibit many attitudes in common especially, as has been discussed, at the ideological level. Similarly, individuals working under common circumstances, in the same or parallel structural positions, hold certain views in common - cutting across professional boundaries. But further examination of responses shows yet another dimension; it relates to respondents' perceptions about themselves, their attitudes and about others.

Objectively, it is fair to say that real problems are thrown up in the course of daily work which are related to different ideological views and which inhibit inter-professional co-operation - and the individuals involved recognise this. Equally, there are many common circumstantial experiences and attitudes which link these same individuals. But as important, are their *perceptions* that they are different and in some sense in opposition. The strength of what Huntington (1981) calls occupational culture, or what here could either be called corporate identity or ***organisational*** culture, fuels whatever cleavages or bondings already exist. But Huntington tends to see professional ideology as a part of occupational culture; as argued earlier,it is perhaps more helpful to separate them as constructs.

Professional ideology relates to particular sets of values and moral attitudes, generally acquired implicitly over time through the

training and induction processes of professional qualification; organisational culture, on the other hand, is a means of drawing explicit boundaries around a group, imbuing the group with a view about itself that proclaims its distinctiveness as being characterised by particular behaviours and attitudes (whether or not it really *is* distinctive). It is the certainty that it is, and the allegiance to the group which that stimulates, that is significant - hence the label 'tribalism'.

In some instances, professional ideology and organisational culture (or tribalism) may act to reinforce each other; the profession may also be the group. This is perhaps true of social work since it tends to be a single profession department (although that is to ignore the differences which are known to exist between levels of qualification and spheres and styles of work - CQSW/CSS; casework/residential care work/community social work, for example). In the case of the health service, there are a number of professional groupings located within the larger organisational space - often with clearly articulated differences in ideology. But those professional groupings tend to coalesce when set against another organisation or agency - such as a social services or social work department. The cleavage then becomes an inter-agency rather than an inter-professional one: one of culture alone rather than a mixture of culture and ideology.

Evidence for this proposition can be found in the present study. Differences emerged between members of social work departments on

the one hand and members (of several professional groupings) of the health service on the other, irrespective of the similarity of many of their views. On occasion, the opposite agency and its members might be ascribed certain views which they did not in fact hold. The issue of community care versus institutional care is a good example of how the members of one organisational culture view members of another in a stereotypical manner.

There were many instances of social work staff stating that all NHS personnel were dominated by 'the medical model', denying the social aspects of illness and dependency and favouring institutional care above community care. A senior social work manager said:

> I think we need to shift resources from the health service to community-based services rather than try to build up some kind of [health service] community resource and let the present level of medically orientated services continue. (32AB)

and a senior social worker said:

> I feel that hospitals have a difficulty in getting people out into the community; partly it's what I call the mother hen syndrome - they're sometimes unwilling to take enough risks and maybe therefore they are not the best people to do that ... kind of thing. Or likewise perhaps they're overwilling to whip people back into hospital and it seems to be a constant dilemma. (13AB)

A basic grade social worker was sceptical of health service commitment to community care:

> Obviously I don't think they're putting their resources into the community. I mean if they were interested in doing that, they would. They haven't got enough commitment to it. (09AB)

And another basic grade social worker was of similar view:

> I think the hospital-type care is less good because of the medical model that is used in the hospitals and from my experience it does exclude the community. (08AB)

The picture presented from the social work side is of NHS personnel overwhelmingly opposed to the move towards community care - partly because of the dominance of 'the medical model', partly to protect the health service 'empire' and partly because of timidity (fear of taking risks). But when many of the health service responses are examined, it is clear that such a picture is a caricature of how many health service personnel feel. A sector administrator, for example, said:

> I would say that if the patient can be cared for in the home and wants to stay home, that should be our ultimate aim although, you know, it may in the end cost more, and more people, social workers, home helps, people that are services, going in. (11JB)

And a senior nursing officer felt strongly about the need to preserve people's independence at home:

> I feel that no matter how humble a home, no matter how tatty it is, I think if an old person can hold on to a scrap of independence, I would certainly be all for trying

very hard to help them keep that independence. (72AB)

Another senior nursing officer also had firm opinions:

> I would like to think it [community care] was people being maintained in their own homes.... I think it could still go much further....If some of that money [spent on a residential unit] could have been channelled into the community, a good 50% could have survived in the community ...and it would have been far better than spending all that and having them all in hospital. (19JK)

A district nurse saw community care as the policy for the future:

> I think it must be the nursing of the future....with a much higher standard ... because now we're going in with this attitude that it's the total person and his family we're concerned with.....There's so much better care to give in the community if there's plenty of backup and support services, definitely. (15JB)

There were many other similar responses from health service personnel along these lines which brings into question the widely held view within social work that NHS staff tend to be opposed to the ideals of community care which social workers see themselves as holding. Such a division of perceptions was brought into play on a number of issues and this seems to to support the proposition that allegiance to one's organisational group and its culture is in many ways as conditioning a factor as those of ideology and circumstance.

Discussion

The threefold framework outlined earlier in this chapter seems to have some utility on the basis of the evidence presented above. While ideological cleavages and the force of circumstance on the one hand explain much of the patterning of attitudes, the notion of cultural allegiance on the other accounts for certain aspects for which there is little reasoned explanation. There is a tendency for individuals, bound together by certain common links, to reinforce those bonds by drawing tight the boundaries between 'them' and 'us' and imbuing each with differences that may or may not exist in reality. Thus, it may be that bonds based on ideological closeness or common circumstance are reinforced and overlaid by cultural or 'tribal' similarities; conversely, in spite of some commonality of views and experience, cultural differences may prove too strong and create separation, suspicion and hostility.

The views outlined in the present study clearly submit themselves to this pattern of analysis; there remains, however, the need to examine how the identification of a number of cross-cutting factors in the previous chapter relates to this present analysis. Do they confirm or contradict it?

The picture which emerged earlier was one of a complex intermeshing of views so that although certain patterns emerged - of inter-professional differences based on ideological views, of

organisational position being a determining factor, of the distinction between being a practitioner or a manager emerging as significant, of a distinction between the abstract and the concrete, and so on -, there were no wholly distinct cleavages.

This certainly fits the beliefs, culture and circumstance framework in which there are distinctive dimensions, none of which however is completely exclusive. It can be persuasively argued that the mesh of cross-cutting factors outlined in the earlier chapter can be organised into this framework. First, the distinction between professional attitudes (professional *qua* professional rather than relating to any particular profession), on the one hand, to the priority policies and both public and official attitudes, on the other, is primarily cast in ideological terms, especially as they relate to the roles of professionals in the playing out of policy. And amongst professional groups themselves, the dominating cleavage is also that of ideology - the beliefs each profession broadly holds about the world and the diagnosis and solution of problems in the world as they relate to professional practice. There is no doubt that these exist at certain levels; what is more, professionals *expect* them to exist. This fuels both the beliefs and culture dimensions of the framework.

The factor of 'agency membership' most importantly perhaps delineates cultural differences. Nevertheless, the way in which the two organisations (local authority department and national health service) work imposes certain bureaucratic constraints which may be

regarded as part of the 'exigencies of practice' or force of circumstance perspective. The significance of a respondent's organisational position and whether or not s/he is a practitioner or manager also relate closely to this latter dimension. According to these factors, particular issues will represent either abstract or concrete concerns; they will have either direct or hypothetical relevance.

It seems, then, that the cross-cutting factors which appeared to confuse the initial propositions and expectations that had existed at the outset of the study can be accounted for when set in the framework of the three dimensions - beliefs, culture and circumstance. In this way a complex and confusing array of sometimes contradictory views begin to take on some coherence. But while such explanation confers coherence, it does not offer any ***simple*** clarification.

A final point worth considering - to what extent might professionals themselves accept this threefold explanatory framework? It was noted earlier that they use the ideological and the circumstantial as explanations for inter-professional and inter-agency failures. The cultural explanation, however, raises questions of 'irrationality', in the sense that it is based on stereotype and inadequate or misleading information. While professionals might accept this interpretation informally, they might be far more reluctant to recognise it publicly. After all, individuals are largely concerned with rationalising their actions, making

apparently irrational acts and beliefs appear coherent. To accept that their behaviour and attitudes are in some ways 'tribal' and culturally determined would run counter to their own interpretations.

CHAPTER EIGHT

CONCLUSION: PROFESSIONALS, POLICY AND PRACTICE

This final chapter will attempt to assess any implications which the findings relating to the patterning of professional attitudes may have for interpretations of organisational behaviour and the policy process as outlined in the first two chapters. In those two chapters, it was argued, first, that for policy to be accepted onto the agenda for action, certain conditions or criteria seemed to have to be fulfilled - and, those achieved, further conditions or criteria had to be satisfied for implementation to be successfully accomplished. Second, it was accepted that what may be called a broadly phenomenological perspective on organisational behaviour can most satisfactorily explain - or at least offer a framework for the explanation of - the significance of the role of actors within an organisation in determining its behaviour. The influence of actors, it was further argued, was manifested in a number of ways and was conditioned, according to the literature, by the ideologies of the professional groups concerned, the 'real life' situations in which the actors found themselves and rationalisations of their actual behaviour in the light of these circumstances.

This, then, was the theoretical framework in which the study was set. It was hoped that a systematic and comprehensive study of the views of a range of professional groups would inform debate about

the policy process. If professionals were able to influence the implementation of policy (either explicitly through control of resources and input into decision-making, for instance, or implicitly through the operation of 'street-level' discretion), then the manner in which their views (which in turn influenced their behaviour) were conditioned and patterned, was clearly an important area for investigation.

It is important to stress that the study was not concerned with 'policy' or 'policies' in the abstract; it was firmly linked to the issue of policy as it related to the dependency groups. This, it can be argued, represents an example of policy which to all appearances has met, at least in part, the criteria of legitimacy, feasibility and support which Hall *et al* (1975) suggest are essential elements in gaining a place on the agenda for implementation: for example, innovative thinking from the world of practice had been incorporated into the official prescription for change (a case of 'ideological corporatism' in Dunleavy's (1981) words) - the remedies for improvement were seen to be *legitimate*; the policy documents mapped out a way forward - they appeared to be *feasible*; central government gave priority to the dependency groups which academics and the official voices of practitioners (via their professional associations, e.g. RCN, 1985) welcomed - the policies thus have had *support*.

And yet, in practice, the policies have not achieved success. The evidence for this is strong. We can take the evidence of several

reports on community care as indicators for whether or not the priority policies have been successful, because embedded in those policies two separate but deeply related strategies were involved: one, that priority should be given to the dependency groups in terms of resource allocation and second, that that priority should enable a transfer of emphasis from institutional to community provision to take place. Both the Audit Commission report (1986) and the Griffiths report (DHSS, 1988) on community care express dissatisfaction with progress made so far; academic research has shown that the development of community care provision has been patchy and of variable standard (Hunter and Wistow, 1987). The report of the Social Services Select Committee (Great Britain. Parliament. House of Commons, 1985) voiced similar views. The explanation lodged in most of these sources tends to be seen in terms of failures in structure, lack of collaboration and absence of commitment.

These explanations, however, merely identify the mechanisms of failure; in themselves, they are not explanations *qua* explanations. The questions remain: what in the structures is antithetical to success? what are the reasons for failure to collaborate? and, what are the reasons for the lack of commitment? There are many interests impinging on the policy process and it is beyond the scope of this thesis to consider all of them. The concern in this study has been to look at the significance of professionals as one of the interested parties in the policy process.

And it is in terms of this - the significance of professionals - that this last chapter attempts some (albeit partial) explanations of the policy failure. Since structural barriers, lack of collaboration and absence of commitment have been identified as some of the immediate reasons for failure, it is worth examining the role of professionals in relation to each of these three factors. This can be done by assessing the findings of the interview study from two perspectives: namely, in terms of the content of views about the policies themselves as expressed by professionals, and in terms of the stances (both behavioural and attitudinal) adopted by some groupings vis a vis other groupings (be they professional or other sorts of grouping).

A. PROFESSIONALS' VIEWS ABOUT THE POLICIES

The picture which emerges in relation to views about the policies is a generalised one of muted support and a degree of equivocation about their timeliness. Support was frequently expressed at the level of generality - that 'handicapped' and elderly people were disadvantaged and had been neglected in the past, they therefore deserved support from society now. Respondents were more reluctant to give wholehearted support when pressed to think what this might mean in practice: although some were prepared to argue for withdrawing resources from the acute sector, for example, many were less ready to support that view. Although most respondents were responsible for providing some aspect of care for the dependency

groups, they were, nevertheless, frequently firm in their support for the acute services - both in terms of the latter's 'trail-blazing' role and the need to restore the health of young, economically productive, but acutely sick, citizens. Support, then, for the dependency groups was to a great extent compromised; on the one hand it was too generalised, too abstract, and on the other hand when it came to practicalities its rival for resources (the acute sector) was able to claim greater commitment.

A related factor was, especially in relation to professions who within their general field of responsibility were responsible for other client groups besides the dependency groups, was the under-valuing of members of the dependency groups. Since the reorganisation of social services and social work departments, following the Seebohm and Kilbrandon reports, social work had become a generic profession responsible for a wide variety of client groups (including, in Scotland, offenders). A number of respondents were aware of the divided loyalties that were at play within their departments. There was a tendency to prefer working with families and young children and a statutory requirement to complete court-related work often at the expense of work with other clients. Respondents accepted that there was a general under-valuing of work with the elderly or with mentally ill and handicapped people; this was reflected within the health service too. The importance placed on the acute sector (revealed in response to questions about priorities) is evidence of this.

In addition to the fundamental lack of support given to the dependency groups, other aspects of the policies, too, failed to claim unequivocal support. The call for greater emphasis on prevention and diversion of resources towards preventive strategies was variably regarded by many of the professional groups. There were some respondents who were extremely sceptical about the efficacy of such strategies - especially at a time of resource scarcity, the consequence of which means the withdrawing of resources from some areas rather than the development of preventive strategies with new money. Calls for better use to be made of existing resources were also met with a degree of scepticism. It was generally agreed that some improvement could be made, but few respondents gave examples from their own areas of responsibility where this might be possible; it was usually in relation to other parts of the service, or relating to relatively small matters (such as making better use of small items of equipment) - or at a generalised level: 'cut down on needless administrative costs', for example.

Scepticism, again, was frequently expressed at the possibility of achieving policy objectives through better and greater collaboration between professional groups and between agencies. The need for such collaboration is seen by policy-makers at the official level as the cornerstone of the priority policies. Although respondents saw it as an admirable goal, which they were happy to support in principle, their estimation of how possible it might be to achieve was coloured

by their experience of inter-professional and inter-agency relationships in the past.

Professional views, then, were equivocal about and unconvinced by the policies. In spite of general support, given at the level of principle by individual respondents and by their professional associations, in practice there seems to be a fundamental lack of commitment to them. This lack of commitment is not mere peversity. It is based on an understanding of the real dilemmas facing the services if the policies are going to be put into practice (the difficulty of making hard - and unwelcome - choices); the knowledge derived from their own experience that collaboration between professions and between agencies is an unrealistic goal; and a natural inclination to protect their own interests and argue for a rationalisation of others'.

B. INTER-GROUP STANCES

We have seen in the preceding section that professionals lack any thorough-going commitment to implementing the content of the policies. Of course, that is a broad generalisation and, as earlier analysis has demonstrated, some professions tend to have differing sets of views from others. Equally, the views of any one profession may be cross-cut by clusterings of views more characteristic of other organising factors (organisational position, manager/practitioner distinction and so on). In addition, professionals' views may be determined not only by a realistic and

rational assessment of the efficacy of policies but by ideological stance, force of circumstance and 'tribal' allegiance. Further, it may not only be *views* that are determined by these factors but also *behaviour* that is thus conditioned.

In addition, then, to a widespread degree of scepticism about the policies in terms of what they propose, which makes for a general lack of commitment to them on the part of many of the actors in the field of policy implementation (i.e. at the point of service organisation and delivery), there are also a number of other factors inhibiting policy success at this level. While policies to improve the position of the dependency groups require the provision of integrated and comprehensive services, the evidence presented here suggests that as far as those who are expected to organise and provided those services are concerned, the goal of 'seamless' care is likely to be subverted by the existence of intervening and fragmenting influences.

It is, especially, the existence of these influences as they affect the capacity for collaboration which is of greatest relevance to the policy issues under examination here. Contrasting professional ideologies separate one group from another; disagreements about appropriate forms and patterns of services stemming from ideologically-derived differences in diagnosis and recommendations for treatment create difficulties in arriving at consensus. Differing agency membership - either through direct employment or through

associated contractual status (in the case of GPs) - accentuates professional differences, or puts boundaries around certain groups of professionals (bringing them into 'tribal' or 'cultural' association with each other regardless of professional contrasts), whilst at the same time excluding others in arbitrary fashion. Force of circumstance imposes other constraints: professionals working in turbulent and constrained environments tend to make compromises, rationalise contradictory actions and turn their faces against co-operation with outsiders.

These factors, it is argued here, go some way to explain the mechanisms for failure as identified in recent reports: that is, structural divisions, failures in collaboration and lack of commitment. The nature of professional beliefs and attitudes and the manner in which these influence professional behaviour are at the root of the explanation. This then leads us to consider what relation this explanation has to bear on the broader analysis of the policy process put forward by, for example, Hall *et al* in their discussion of legitimacy, feasibility and support as key factors in policy success.

C. PROFESSIONAL BELIEFS AND BEHAVIOUR AS FACTORS IN THE POLICY PROCESS

In the first chapter of this thesis, some brief consideration was given to the ways in which a number of sociologists and social policy analysts have accounted for the introduction of certain

social issues onto the policy agenda and the degree to which they have been successful. Whether or not an issue was recognised as significant was problematic in itself - it depended, the arguments seemed to suggest, not on the intrinsic worth of an issue (defined in rational, objective terms) but on other, extraneous, factors, such as the moral climate, the existence of structural interests, lobbying or interest group activity, and a variety of politico-economic factors. Blumer talked about the need for societal recognition, legitimation, mobilisation of action, an official plan and implementation; the argument here would suggest that the degree to which any of these might emerge would depend on a mix of the factors enumerated above. Likewise, the stages outlined by Spector and Kitsuse - statement of problem, official response, re-statement and action - are likely to be governed by similar factors.

Hall *et al* proposed the legitimacy/feasibility/support triad of conditions as prerequisites for success. As noted earlier, they were discussing social policy at the national level - how policies are introduced onto the national agenda. Support as they discuss it, predominantly relates to support of the government of the day, rather than support for the policy itself. Nevertheless, once a policy is adopted onto the national agenda, it then has to be implemented down through many levels of the system. The support which is regarded as necessary at the national level - public support for government or 'support for the regime' - becomes transformed; at the stage of implementation, the support of the parties involved in that implementation becomes necessary. It is at

this stage the significance of professionals - those charged with its implementation - becomes significant.

Likewise, the notion of feasibility may be transmuted during the course of the policy process. At one stage and at one level, it might be a question of assessing the practicalities of obtaining support and achieving implementation in an objective fashion - balancing the options both for and against - but at a later stage and a lower level, other factors - difficult to predict or estimate at the outset - may intervene and bring the feasibility of implementation into doubt. Again, the intervention of professional resistance - or at minimum, lack of professional commitment - or, further, the fragmentation of the professional response may be significant factors inhibiting the process. Feasibility as perceived at one level may be transformed into exhortatory chiding at another: the stream of reports coming from central government over the years calling for greater collaboration between agencies and between professions to overcome structural divisions is evidence of this.

There may be consensus at a particular level of generality, likely to be located at the national level, of the legitimacy of a particular issue. Government, civil servants, the official voices of professional practice and lay (or consumer) opinion may all apparently validate particular policy items. It is only in the playing out of the policy process that the consensus fragments into its constituent members, each of which will articulate its own (possibly contentious) position.

It seems reasonable to propose that the case of the priority policies is just such an example. A general consensus at national level appears to be insufficient to secure successful implementation of the policies in practice. The study of professional views, which has been reported in this thesis, offers a partial insight into why that might be so. The constellation of professional (and other) interests influences attitudes towards the substance of the policies. Further, the specific construction of professional (and other) ideologies and assumptions conditions behaviour which has repercussions for the success of policy implementation. If beliefs, culture and circumstance are the determinants of the patterning of views which mould professional behaviour, as has been argued here, then they are also necessarily formidable factors - or inhibitors - in the playing out of the policy process.

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APPENDIX I

The interview schedule

BIOGRAPHY AND EXPERIENCE	AREAS FOR EXPLORATION
1. What is your current post	
2. What qualifications do you hold	Degrees, diplomas, and/or on-the-job training
3. Could you tell me briefly what posts you have had before this present one, and how far they have involved work relating to the dependency groups Supplement: Has this involved -hospital work -residential work -community based work	If necessary, remind which dependency groups we're interested in; (frail and confused elderly, mentally ill, mentally and physically handicapped, chronically sick) Don't let respondent stray too far re past experience
4. Are you a member of any professional association - if so, which Supplement: (for social workers who have not mentioned b elonging to BASW) Is there any reason why you are not a member of BASW?	

JOB DESCRIPTION

5. Could you give me a brief (job) description of your present post

Probe for

(a) Social Workers (fieldworkers)

(i) Amount of time spent on work with clients in dependency groups

(ii) Does size of case load mean less time for DGs and more on statutory duties, other client groups, or paper work

(iii) How far is there a choice in regulation of own case load, and choice in allocation of types of cases

(iv) Would you like more choice. If so, what

(v) Where do you think your department's priorities lie, in relation to the DGs

-- which other groups take priority
(areas to explore: child care, non-accidental injury, court work)

-- do unqualified staff take on DG cases

(b) Residential Care Workers

How much contact do you have with the department, and how far are you left to get on with the job

(c) Social Work (managers incl. senior social workers)

(i) What part do you play in allocation of cases, and therefore in determining how much time the department as a whole spends on working with clients in the dependency groups

(ii) How far is it part of your job to represent views from below up to senior management, and how far is it part of your job to represent senior management down to those below you

(iii) How does that work - Probe for examples
Do you carry a case-load or is all your time spent in supervision and administration?

(d) GPs

(i) Broadly how much of your time is spent dealing with patients with chronic conditions during surgery time

(ii) How much of your visiting time is spent visiting patients in the dependency groups on a routine basis (rather than visiting other patients on an emergency or crisis basis)

(iii) Is it part of the GPs's role to be concerned about the social problems of a patient, or is his role to treat the presenting condition

(iv) How far do you as GP act as a referral point for patients, channelling people on to the right agency or source of help (and which agencies does he refer people on to)

(v) How far do you see yourself as part of a Primary Care Team - are there health visitors, district nurses, or social workers attached to the practice, and if so, does the team concept work well

(e) Nurses (Ward sisters)

(i) How far are you concerned with the care of patients in the dependency groups

(ii) Did you have any preference
Do you have any choice in which patient group you care for

(iii) Do you have any preference for particular patient groups
now have

For example - between acute or chronic illness

or - for one particular patient group (esp. a dependency group)

(iv) Do members of all the different professions or occupations working on your ward see themselves as a team? Are you encouraged to see yourselves as a team either by the consultants or your own line management

(v) Do you feel you are able to spend enough time involved in patient care or do you spend a lot of time in admin. and supervision? And if so has that become a trend in nursing generally

(f) Nurses (managers)

(i) How much time if any are you able to spend involved in patient care

(ii) Do you feel nursing management has become distanced from the patients as some nurses might say

(iii) Do you see yourself as representing junior staff's views up to senior management and also channelling senior management's views down to junior staff

(iv) Have you specialised in one field of nursing (eg. geriatrics)

(g) District Nurses/Health Visitors

(i) What proportion of your time is spent working with patients in the dependency groups and what proportion spent with mother and child cases

(ii) Are you able to choose which cases you take on? If not, how is allocation made

(iii) If you were, or are, able to choose, which patient groups do you like working with, and why (If not the DGs, why not)

(iv) Where do the priorities of the Community Health division lie in terms of patient groups

(h) Consultants

Ascertain whether respondent deals exclusively or partially with DG patients
(This will depend on the specialty)

(i) Do all your patients fall within the category that this project has designated 'dependency groups' (If necessary, list them)
If not exclusively, what is the balance between patient groups
and Does respondent have any preference for a particular patient group. If so, why

(ii) Are there members of other professions and occupations (apart from nursing) involved on your wards, such as Health Liaison officer, Social Worker, OT or a physiotherapist
Do you see yourself as leading a team and, if so, what is your role
Do you have regular ward meetings where all professions meet and discuss ward and/or patient problem

(iii) Do you feel it is part of your role to be concerned with a patient's emotional and social problems as well as treating him for the specific condition for which he has been admitted
eg. How far are you concerned about the situation he will be going back to at home once he is discharged, and would it have a possible effect on your decision as to when to recommend discharge

(iv) What is your relationship to the hospital administration
Do you sit in on any joint committees within the hospital, and what are these for
How much contact do you have with senior people in the Health Board - and for what sort of purposes
(NB This may lead directly in to the following question about inter-professional, inter-agency problems)

Community Medicine Specialists

(i) How far is your work concerned with the patient groups we have designated as 'dependency groups'
What sort of services for these groups, if any, are you responsible for

(ii) Who are you directly employed by

(iii) What is your relationship to the Community Health division of the Health Board - how do you link with it
eg provision of services, committee membership, meetings

(iv) Do you feel the Community Medicine is given enough priority in health service planning
If not, in what way would you like to see it developed

(j) Sector Administrators

(i) Do you see yourself in the role of co-ordinator - of the services, within this sector, and of the professions and occupations working within this sector

(ii) Do you see industrial relations as a major part of your post

(iii) Are you in a position to balance the amount of services given to the different categories of patient within your sector, or is that determined elsewhere
If so, where is it determined

LIASON WITH PROFESSIONALS (OWN AND OTHER) AND BETWEEN AGENCIES

6. We want to investigate the extent to which difficulties occur in the relationships between different professionals or agencies that deal with dependency groups. We mean here your relationship with other people in your field, those in other fields and other agencies.

(a) First, which professions or agencies do you come into most contact with in your work with dependency groups

Ask about each mentioned: problems and successful relationship

Prompt for specified others not mentioned

(b) Are you conscious of difficulties of this nature in other members of staff above or below you - if so, what and why

(c) Do you know of any formal links that exist between the Health Service and Local Authority departments and do you think they are effective

Informal links as well.

Professions/Occupations

Social workers, health visitors, OTs, district nurses, GPs, hospital nurses, administrators, and managers (of all sorts), consultants

Physios.

Agencies

Health service, Local Authority departments - social work, housing

NB Services based in both hospital and community, eg. social work and occupational therapy

Problems (professions)

Individual relations
- different professional attitudes
- lack of understanding of other's roles

Overlapping job remits
Different aims and goals
Status differences
Lack of understanding of each profession's own difficulties

Problems (agencies)

'Red tape'
'Bureaucracy'
Absence of formal or informal links at relevant level
Different lines of accountability
Different sources of funding
Different definitions of need and forms of care

POLICY FORMULATION

7. We are interested in the extent to which people feel they are able to influence decisions within their organisation, both informally and formally

(a) Are you a member of any committee or working party or do you attend regular meetings where decisions or recommendations are made

If so - what sort of issues
- what representation

N.B. especially issues relating to the DGs.

(b) How do you feel policy gets made in your organisation, and who makes the decisions

(c) Do you feel you have an opportunity to make your views known within your department/ organisation

and

Do you feel you are able to influence or participate in policy making

In what way

Examples

Setting of priorities,
Day to day decisions
Policy from above or below
Consensus or conflict between different interest groups

CONSTRAINTS

8. Can you identify any major pressures or constraints under which you have to work at the moment

Shortage of material resources
Shortage of staff
Competing claims of different patient/client groups
Inefficient organisation (in own or collaborating one)
Bad channels of communication

COMMUNITY CARE

9.

(a) The phrase 'community care' is used often in recent policy documents and there seems to be a debate among professionals about the balance between community vs. institutional care. Can I just check your definition of the term. Would you include such things as old people's homes, hostels and half-way houses, as against hospitals, within that term, or would you say it only referred to people being maintained within their own home

9. (b) Some professionals would say that, within existing resources, the move towards community care has gone as far as it can. Others say that it could still go much further. On balance, on which side of the debate do you stand Probe for next steps in provision (if pro - more community care)	Extreme examples would be to say that all psychiatric hospitals should be closed down or fostering rather than any form of residential care for mentally handicapped or elderly
FAMILY RESPONSIBILITIES 10. We're interested in the balance between family and state responsibilities for the care of the dependency groups - especially at this time of scarce resources. Some people feel that the family should take prime responsibility for their dependent relatives, whilst others feel that it's the state's responsibility. (a) What is your view (b) Do you think we have fallen behind in the provision of professional services for family support or do you think existing provision is more than adequate (c) Would you answer similarly for all dependency groups or would the nature of a particular condition influence your view Which conditions would alter your views and why	Do they feel families' responsibility varies depending on the condition, say, between, mental handicap and the elderly or mental illness and physical handicap
VOLUNTARY SECTOR 11. (a) What role, if any. should the voluntary sector play in caring for the dependency groups If yes - what sort of voluntary effort should be encouraged and what form should it take (b) Have they or their organisation had experience of working with voluntary organisations or volunteers	NB distinction between voluntar organisations (which may have paid staff) and volunteers who may be unco-ordinated and sporadic (and therefore difficult to utilise)

12. Have you had any personal experience of caring for a dependent relative

If yes - probe

- effects of doing so

- greater understanding of problems involved in care arrangements

PUBLIC EXPECTATIONS

13. Does the general public expect too much of the services available for the dependency groups

14. Are people willing enough to take responsibility for their dependent relatives

PRIORITY GROUPS

15. Do you agree with government policy over the last decade which says these groups should have priority over other groups in health service planning.

If so (on the assumption that there will be no new money available)

- which other groups or sectors of the services should lose resources

List dependency groups again: frail and confused elderly, mentally ill, mentally and physically handicapped, chronically sick

eg. acute medical services, such as transplants

or only with new money

16. Do you think any one particular dependency group should have priority over the others

Probe - why do you feel that?

Do you think any one group has been particularly badly served so far

- which one, and in what way

ALLOCATION OF RESOURCES

17. It seems unlikely that there is going to be much new money coming into Health and Social Services in the near future.

In this case should existing resources for these groups be reallocated in order to provide better integrated services

For example/

For example

(a) Could resources be transferred from one service to the other (say, from Health to Social Services)

or even Could both Services (Health and Social Services) be amalgamated for purposes of community care provision

eg. If a psychiatric hospital is going to be run down, shouldn't the money saved be transferred to services for caring for ex-patients in the community

or could not the NHS pay for home helps for its patients on discharge from hospital

NB In Northern Ireland, health and social services are combined - some respondents might refer to this

(b) Could there be more joint projects set up, with Support Finance, where the NHS and Local Authority collaborate in the provision of specific schemes

eg Hostels,
Sheltered Housing

18d. Another way of shifting resources is by putting greater emphasis on prevention. Do you think enough emphasis is placed on preventive work in both health and social services at the present time

If not - probe

eg health education
campaigns
screening
change in life styles, health habits
social change (reduction in unemployment)

19. Finally, do you think better use could be made of existing resources

If so - in what way

Cutting out waste
Better organisation

SPECIFIC SERVICES

20. We have discussed possible directions in which resources could be allocated in a general way

Which is the single most important service that you would like to see introduced or expanded in one or all of these four service areas

(a) NHS community provision

(b) NHS hospitals

(c) SW residential

(d) SW community based provision

NHS community

nursing homes
district nursing
health visiting
night services
short term relief

NHS hospital

day hospital
improvement of wards
more staff
more beds

SW residential

homes (OPHs, Children's Homes)
hostels
half way houses

SW community based

day centres
aids/adaptations
home helps
meals on wheels
individual family casework

21. We are interested in the dependency groups partly because they have been pinpointed by Central government. Is this policy clearly stated within your own organisation and are you aware of it in relation to your own work

Probe - Do you see a real need for more clearly stated policies within your own organisation
[for consultants -- by the Health Board]

APPENDIX II

Working paper

THE EFFECT OF STRUCTURAL POSITION ON PROFESSIONAL ATTITUDES: THE CASE OF MIDDLE MANAGEMENT AND THE FRONT LINE

Section One

Resume of Two Earlier Papers

This paper builds on the findings outlined in the two earlier papers which examined responses to 40 interviews conducted in Glasgow, covering a wide range (both vertically and horizontally) of health service and social work professionals. These two papers provided a basis for the analysis of the whole of Project Professional, although leaving many aspects unconsidered, and yet others only tentatively approached; the method of analysis adopted proved appropriate and some of the findings seemed to point in directions which might prove fruitful when more transcripts are examined. In the first section of this paper, I want to review some of those findings in order to remind workshoppers of the sorts of things that seemed to be emerging there so that they can bear them in mind when reading this paper. The overall purpose of this paper is to look at a dimension which was impossible to take into account in the two earlier papers because of the practical problem of lack of numbers. In those papers I was mostly concerned with testing my techniques of analysis, and did not expect to be able to say anything definitive about any particular set of respondents. I drew tentative conclusions about particular professional groupings (e.g. 'consultants', 'social workers', and so on) but nothing more. It was felt that a useful step forward would be to look at the responses according to a dimension that cut across that of professional grouping - i.e. that of hierarchical position (and, as also is the case, the dimension of 'the nature of the work done' - practitioner/administrator). I have therefore looked at respondents according to whether they are front-

line workers (health visitors, basic grade social workers, district nurses, ward sisters, GPs) or lower/middle management (divisional nursing officers, sector administrators, social work area officers, occupational therapy organiser, home help organiser, homes and centres supervisor); in order to be able to do this, I had to look at another 16 respondents so that from a total of 56 transcripts analysed I was able to contrast 25 front-line workers with 17 lower/middle managers.

But to return to the earlier papers, I shall briefly describe the sorts of results I was able to obtain from the method of analysis which I had adopted. I took a selection of response headings from the interview outlines and concentrated on building up sets of responses under these headings in order to see what sorts of patterns emerged. The response headings were as follows:

1. Experiences of inter-professional differences
2. Constraints experienced in putting daily work into practice
3. Respondent's definition of the term 'community care'
4. Respondent's view of the balance between family and state in the provision of care for dependent relatives
5. Does the public expect too much of the professional services?
6. Does the public generally take enough responsibility for the care of dependent relatives?
7. Does the respondent agree with government priorities (for the DGs)?
8. Which other sector should therefore lose resources?
9. Which group should have greatest priority?
10. How could resources be reallocated in order to improve service provision and achieve the priorities?
11. Is enough emphasis put on prevention?
12. Can economies be made, in terms of elimination or waste of more efficient organisation?

Results

1. Inter-Professional Differences

The second of the two papers dealt solely with this large topic; instances of inter-professional differences seemed to fall into 4 categories, which I loosely referred to as hierarchy/organisation, overlap in job remit, professional orientation and practice and 'denigration'. These were not altogether satisfactory - the first, for example, should, with large numbers of respondents being considered, be split into two separate categories, likewise orientation and practice. 'Denigration' is a category that needs some re-thinking and refinement, too, to pinpoint more precisely the nature of the attitudes being expressed. However, as a rough working categorisation the four headings indicated the way ahead. I was able to look at where most of the problems were felt to lie by most groups and which groups were targetted most strongly as being difficult to collaborate with. District Nurses and Social Workers (of several levels), for example, complained most, and social workers tended to be the most complained about. There did seem to be some indication that the position of a respondent in the hierarchy of her/his organisation might affect the degree to which inter-professional collaboration was perceived of as problematic and the particular categorisation of the type of complaint made (front line - vehement, professional orientation and practice; management - benign, bureaucratic and organisational). This was, thus, one of the reasons for the present paper.

2. Constraints

Responses to the question about constraints fell into 9 different types:

1. Workload
2. Staffing levels
3. Industrial action
4. Scarcity of resources
5. Effects of the cuts
6. Professional matters
7. Nature of the work
8. Other agencies/professions
9. Structural

(It should be noted that the question was always broached in the broad terms of 'constraints', unqualified by any of the categorisations outlined above.) Again, the sorts of constraints which were perceived varied as much according to structural position as according to profession - for example, managers seeing staffing levels as a major constraint being equivalent to front-line workers' problems of workload.

3. Definitions of Community Care

Three categories of definitions emerged:

1. All outside hospital
2. Everything except hospitals and residential institutions (OPHs, children's homes) - including hostels, half-way houses, group tenancies
3. Own home

There was some tendency for social work personnel to opt for narrower definitions than NHS personnel, and that it was also related to how the respondent's own job was defined.

4. Balance between Family and State

Responses were spread across a four point range: primarily state; partnership between state and family; primarily family with state support; primarily family. Social work personnel tended to opt for greater state support than NHS personnel who were more evenly spread.

5. Public Expectations

There were three possible responses - expects too much; not too much (or too little); can't generalise (or 50/50). More NHS personnel felt that the public expects too much than did social work staff.

6. Public Responsibility

There was a similar three point range of response: enough responsibility; not enough; can't say (or 50/50). There was a generally positive view of the public's willingness to care, with especially strong social work support for this view.

7. Government Priorities

A large majority (31 out of 40) were in favour of the priorities, though some were more wholehearted than others. Those disagreeing often had responsibility for non-DG groups which may have influenced their views.

8. Sectors To Lose

While a majority favoured priority for the DGs there was great reluctance to point to sectors which should lose; there seemed to be a tendency for managers to be more reluctant in specifying which sectors should lose than for front-line workers. The acute sector, high-tech/research and administration were all cited as possible areas to lose, but only by a minority of respondents.

9. Which Group

Most respondents favoured the elderly, but a sizeable number felt that priority should be spread evenly over the whole group while another, equally sizeable number, felt unable to comment because they did not have enough facts.

10. Reallocation of Resources

Nearly half of respondents felt improvements could be made by reallocating resources - methods ranged from amalgamation of services to collaboration through a variety of means (direct transfer, support finance). NHS personnel tended to favour amalgamation under NHS control, while SW staff favoured collaboration. A great deal of scepticism about the success of such schemes was expressed - in terms of professional or structural reasons.

11. Prevention

Positive responses on prevention fell into three categories - broadly described as health education, technical and interventionist. A majority favoured more emphasis on prevention but a large number were sceptical about its worth. Some felt strongly in favour of one form of prevention and yet hostile to other forms.

12. Waste, Economies

A majority felt better use could be made of existing resources, by cutting out waste and improving efficiency. Improvements suggested fell into three categories - better use of equipment, pruning administration and rationalisation of service organisation.

Section II

I am primarily concerned with the effects of structural position on attitudes in this paper. However, it is important to realise that along with difference in structural position (bottom of the hierarchy/some way up the hierarchy) goes the difference in the nature of the work done (practitioner/administrator) and that these two factors must be intertwined in the effects they have on attitudes. It may be possible to unravel the differential effects of structure and 'work done' when differences between lower managers and senior managers are examined - thus, there would be no such qualitative difference in the nature of work done, rather degrees of responsibility, overview, power to make far-reaching decisions, and so on.

However, for the purposes of this paper, it is going to be impossible to make any clear distinction between structure and 'work done', although there may be some pointers. The questions which I shall primarily

address are these:

(a) How far is professional adherence stronger than the practitioner/manager cleavage. The responses which perhaps will reveal this most precisely are those related to resource reallocation, (sectors to lose) definitions of community care, constraints on daily work (because they relate to degrees of experience of the practical problems, the degree to which respondents are required to make decisions - or remain neutral as the case may be - and knowledge of organisational issues within respective agencies).

(b) How far do managers as a whole, or front-liners as a whole, exhibit common politico-moral views, or how far are these fragmented according to profession. (The relevant questions here will be the family/state question and those inquiring about public expectations and public responsibility).

(c) Is there a different perception of inter-professional/inter-agency problems as between managers and practitioners. For example, do managers see them as structural/agency determined, and do practitioners see them as profession- or personality-based). Do managers see fewer problems, and have a rosier view of the scene on the ground than practitioners. Since it is part of their job to run the service smoothly and therefore they need to see themselves as being successful at doing so. (Obviously the responses on inter-professional collaboration are the relevant ones for scrutiny here.)

In this paper I shall look at response headings in relation to the three questions outlined above and then look at any remaining response headings which may or may not be relevant to the three questions.

Before looking at the results I will characterise the sample under scrutiny. I have examined transcripts of interviews with 25 front-line staff (FL). They are composed of: 5 Health Visitors, 5 District Nurses, 5 Basic Grade Social Workers, 4 Ward Sisters and 6 GPs.

I have included GPs because they are undoubtedly at the 'front-end' of patient care; however, their structural position is atypical - independent contractors within the NHS, gatekeepers for many other services and so on.

They may present quite different responses from other FL workers and managers.

I have analysed transcripts of interviews with 17 lower/middle managers (MM). They are composed of: 4 Divisional Nursing Officers, 4 Sector Administrators, 6 Area Officers and Principal Officers (Social Work) and 3 Social Work Administrators (Homes and Centres Supervisor, Head Occupational Therapist, Home Help Organiser).

1. Professional Adherence/Hierarchical Cleavage

Constraints

(see Table 2 for comparison of results)

FL workers are far more concerned about workload and staffing levels (18.5 + 33 = total: 51.5) than are MM personnel (15.3); most significantly, while all 5 District Nurses, three of 5 Health Visitors and two out of 4 Ward Ssiters cite these as constraints, none of the NHS MM personnel (Divisional Nursing Officers and Sector Administrators) mentions them as perceived constraints. For all 4 Sector Administrators it is scarcity of resources (i.e. finance) which is mentioned (together with a structural factor - no decision-making power), and for Divisional Nursing Officers it is more mixed - scarcity of resources, industrial action, lack of DEG understanding and lack of management power (similar to the structural problem mentioned before), together with problems in the quality of staff. Social work managers (9) mention staffing levels four times, while scarcity of resources also figures prominently. Basic grade social workers are concerned about workload and staffing levels on three occasions but also about scarcity of resources and cutbacks (2), powerlessness (1) and bureaucracy (1). GPs sometimes feel overworked (2 out of 5), otherwise it is predominantly shortage of facilities for the elderly which concerns them. One GP (who will continue to be mentioned individually) feels he has no problems at all.

How far, then, does this point to any cleavage between management and front-line, or how far do professions stand together in their perceptions of daily problems? Clearly, there is an overall difference in the degree to which FLs see pressure of work (expressed as workload, staffing levels) as a major problem (there is no particular evidence, as suggested elsewhere, that managers may see the problem as 'staffing levels' while FL workers see it as 'workload') and the degree to which managers recognise it (FL: 51.5; MM: 15). Within these clusters, FL nurses (district nurses, health visitors, ward sisters) are very strongly concerned, while their managers barely mention it. These managers are much more concerned with scarcity of resources, the effects of the cuts and industrial action. Of course, pressure on front-line staff may well be a direct result of this scarcity and these effects, but perceptions of the same problem are clearly different between the front-line and some way up the hierarchy. There is no such clear-cut distinction betwene social work categories - in fact, SW managers are as concerned about staffing levels as FL workers. This may be due to the nature of SW management. In fieldwork management, the resource to be managed is largely staff (in contrast to NHS managers - sector administrators and even divisional nursing officers - equipment, wards, patients and staff), so perhaps it is not surprising they should express concern about staffing levels. The lack of clear-cut distinction within social work is worth noting in order to see whether it is a distinction which persists throughout, or whether structural factors supersede in other contexts.

Definitions of Community Care

(see Table 3)

There are some marked differences in definitions of community care between FL and MM workers. Far more FL workers are prepared to see any form

of care outside hospitals as community care (52: 35); on the other hand, more MM workers are prepared to restrict the definition to 'own home' (29: 16). Roughly the same number (32: 35) take the middle course and opt for care outside hospital and residential institutions.

When choices according to professional grouping are examined, there is less consistency as between FL and MM than at first appears. The high level of responses for A (outside hospital) amongst FL workers is due to the numbers of GPs (5 out of 6) Ward Sisters (4 unaminously) and District Nurses (3 out of 5) opting for it. BG social workers opt unanimously for B and Health Visitors spread through the 3 categories. Amongst MM workers, the spread is much more even throughout all professions:

(Div. Nos = A:2, B:1, C:1 Sect. Admins. = A:3, B:1 Area 0 and P. 0
Social Work = B:3, C:3 SW Admin. = A:1, B:1, C:1)

However there does seem to be some indication that preference for A is stronger in all NHS professions except for health visitors :

(NHS (all professions) total responses = A:18, B:5, C:5
SW (all levels) total responses = A:1, B:9, C:4)

than amongst social workers of all levels. This may well be due to the fact that there is a tendency fostered within the health service sector to see anything outside hospital as the community, without any effect being made to understand the finer distinctions drawn between different types of care.

As in the case of the <u>constraints</u> responses, it appears that the strength of agency (in this instance the health service) attitudes outweighs the hierarchical distinction (FL/MM). The consistency of social workers to favour B may well reflect the prevailing ethos in social work, the profession, of the all-embracing nature of community <u>outside</u> large scale institutions (whether health or social service-run)

although always built on a replication of the family model. Perhaps this indicates that social workers are more directly motivated by the ideological positions taken up by their profession as seen in their training curricula a content, and the public statements of their profession. (Again this is something to bear in mind during the course of analysis).

Resource Reallocation

There are two possible outcomes in the comparison between FL and MM workers. The first might be that FL workers were found to be extremely sceptical about the possibility of amalgamation or collaboration in the light of experienced difficulties in the inter-professional, inter-agency context of the front-line. The second might be that MM workers would be far more sceptical or reluctant to commit themselves to a positive response because of their direct experience of having to make decisions about resource allocation under present (difficult) conditions.

On examination of the results (Table 10), it appears that FL workers are the most sceptical. Health visitors are unanimously so; GPs - 5 out of 6; Basic Grade Social workers - 2, sceptical, 2 find it too difficult to comment on, and only one is in favour. Three out of 5 district nurses are in favour of amalgamation and/or collaboration, likewise 3 out of 4 ward sisters. Even where respondents are in favour, several (NHS respondents) suggest that social work should come under health service control, or that it is 'generally a good idea' without looking at the issues practically.

MM workers while less sceptical (47: 56) are not wholly in favour of greater collaboration or amalgamation; those in favour again mention greater NHS control or a model similar to the Northern Ireland

structure - which would imply a similar centralised control in much the same way as the NHS. Opinions in favour or against are spread evenly through professional groups - interestingly the sector administrators for a community health division is one of those in favour of collaboration, and must be one of those with most direct experience of contact with 'the other side' (the Local Authority).

In this set of responses, it seems that there is a degree of scepticism generalised amongst all respondents but that FL workers tend to be more sceptical than MM workers. This would suggest that it is the experience of work at the front-line which conditions their responses, and that in this case the hierarchical cleavage is more significant than professional adherence. This conclusion will be important to bear in mind in considering a comparison between experiences of inter-professional, inter-agency collaboration.

Sectors to Lose

(see Table 8)

Both MM and FL workers are loath to see any sector losing resources (17:6:29) although FL staff are prepared to specify particular sectors to lose more readily than their MM counterparts. Of those sectors which should lose they suggest high-tech developments in three instances, and the acute sector generally in one case. Three other respondents suggest a reorganisation or redeployment of current services would be appropriate.

Amongst MM workers, of the three respondents who suggest sectors which could lose, two specify the acute sector (in health) and one suggests a redefining of social work priorities in favour of the DGs at the cost of problem families and children.

While both groups (MM and FL) feel strongly that no sector should lose resources, and more FL workers are prepared to specify those sectors which should lose, if necessary, what is perhaps most significant is the

number of MM workers who are reluctant to make any choice at all - 35 (MM): 12.5 (FL). This fits the pattern that MM workers are less prepared to make choices, because of their awareness of the difficulty of decision-making through their own proximity to those processes.

Conclusion

How do these findings, then, provide any answer to the general question of structural cleavage as opposed to professional adherence? It seems that in the case of two sets of responses (constraints and community care) professional adherence does seem to underlie social work attitudes although it certainly does not have any impact on professional groupings within the NHS. This, then, has the effect of creating an agency-based division as between the NHS as a whole and social work (the Local Authority).

However, it should be noted that when the figures are looked at generally in each case (constraints, community care, and resource allocation and sectors to lose) there does seem to be a significant difference between FL and MM views. In the resource reallocation case, there is certainly no agency-based division, and what difference there is, is certainly based on hierarchical distinction; the same is true for sectors to lose.

2. Politico-moral Views

Family/State

(See Table 4)

Both sets of workers opt for response C in a majority of instances (Primarily Family + professional support). However, faremore MM workers select this option than FL workers (76: 36). But far more FL workers opt for response D (Primarily Family) than do MM workers (28:66). When both sets of responses are added together (Family and Family + support) the difference is not quite so great (64(FL): 82 (MM)). The same numbers in each grouping opt for response A (Primarily State) while more FL workers choose B (Partnership between family and state).

GPs and Ward Sisters consistently choose C and D (the family options); no social worker chooses D (A:1, B:2, C:2) while health visitors and district nurses are spread more evenly (HVs = A:1, B:1, C:2, D:2 DNs = B:3, C:1, D:1).

Amongst MM workers, there is clearly very marked consistency for option C (Family and Professional support. This is spread evenly amongst all professional groups (4 out of 6 SW, 3 out of 4 Sector Admin., all Div. NOs and 2 out of 3 SW admins.). Only 3 MM workers opt for A (State) or B (Partnership) and these are all from social work.

Clearly the pattern of choice for option C is significant; is it the softest option, which has fewer 'political' implications - A and B (and D) can be seen to have greater overt ideological content - so that MM workers with little direct contact with the public can select that option without facing the problems faced at ground level? Are the 3 respondents from SW who opt for B (2) and A (1) expressing some of the ideological motivatino suggested under the previous section and is this motivation also present in the choices of Basic Grade Social Workers (2 B and 1 A). However, ideological motivation is not necessarily

straightforward in the social work context - for example it is possible to identify at least two parallel strands of ideological thought in social work: one, the view that the state has a responsibility to protect its weaker members and that social workers are the agents of that benign state and two, that social work should be merely a 'facilitator' to enable people to take power into their own hands and learn to do things for themselves. It is possible to identify the pro-state and pro-partnership responses with the first position and the pro-family responses with the second.

It may also be that front-line workers generally have a more jaundiced view of the public and the public's duties, simply because of direct experience, and that this causes them to have a more varied view of the balance between family and state.

It does seem fair to conclude that in this case there is a clear distinction for whatever reasons between FL and MM respondents, although there may be some tendency for all social work respondents to exhibit some similar attitudes.

Public Expectations

(see Table 5)

Perhaps the most significant result here is the fact that a majority of FL workers feels that the public expects too much of the professional services, in contrast to MM workers (50: 29). Almost exactly the same numbers in each group feel that the public either expects too little, or at least not too much (41.5: 41); but far more MM workers than FL feel that they are not in a position to generalise.

Amongst the FL workers, it is mostly NHS workers who feel the public expects too much, while basic grade social workers are much

more pro-public (B:3, A:1) although one SW respondent does feel people expect too much. It may be that district nurses and health visitors express this view of the public as a consequence of their general feelings of over-work (as seen in the constraints questions). GPs are almost unanimous in their jaundiced view of the public (5 out of 6 think they expect too much) and perhaps this goes along with their view that it is primarily the family's duty to take responsibility.

MM workers take a much more guarded view, especially in terms of the numbers (29) who feel unable to comment through lack of knowledge, or the general feeling that 'some do, some don't expect too much' of the services. Interestingly, social work fieldwork managers express a degree of seepticism about the public (3 out of 6) while no nursing managers express these views. Sector administrators are the only other managers are the only other managers who express this scepticism (2 out of 4). Reluctance to express views is spread evenly throughout. It It seems therefore that there is a clear distinction between FL and MM, and that neither the agency cleavage described elsewhere nor professional adherence is evident here.

Public Responsibility

(see Table 6)

Differences between FL and MM are perhaps even more marked in response to this question than earlier ones. At the same time, there is an increased reluctance to express any view at all - generally through lack of knowledge, or the view that 'some are responsible but some are not'.

Amongst MM workers, no SW managers feel that the public does not take responsibility, it is only amongst Div. NOs and Sector Administrators

that this view is mildly expressed. The reluctance to express an opinion is spread evenly throughout all professional groups.

The anti-public response amongst FL workes is boosted particularly by the hard line attitudes of GPs (4 out of 6); otherwise these views are spread evenly, though not in great nubmers throughout all groups. It may be that GPs have to be extracted and looked at quite separately because there seems to be a tendency for their views to disturb the balance of other FL views. However, in this case, it may well be that the general jaundiced view of FL workers about the reality of the social and health problems which they meet on the ground is reflected in their responses.

For the purposes of this paper, though, it may be valid to suggest that the cleavage is structural in this case, and that profession and agency are not relevant.

Conclusion

These response sets purport to answer the question about FL/MM politico-moral attitudes. It seems apparent that in this case there is some justification in suggesting a cleavage between groups on hierarchical grounds, although it is not easy to explain why this should be so. Why should front-line workers whose remit is specifically to help people at the front-line express harder-hearted attitudes towards their patients/clients than their managers do. It may be that the conditions of that work (as expressed through the constraints question) create a generally jaundiced, sceptical attitude, or a more realistic attitude; it may be that managers do not take the question as seriously as front-line workers, and answer it with less realism. It is difficult to discern any clear pattern produced by profession/ideological motivations, although this does seem to be apparent in the first section, relating to questions regarding resource allocation etc. This may be because

of the smallness of numbers involved and should not be regarded as conclusive.

3. Perceptions of Inter-Professional, Inter-Agency Problems According to Structural Position

(see Table 1)

It is difficult to do justice to the responses under this heading without going into greater detail and referring back to transcripts for greater density of evidence. As I do not have time available for this here, I shall simply attempt a very cursory overview, to indicate in a small way the line that such a detailed consideration might take.

In addition, to the four-fold classification of responses which I adopted in an earlier paper (rather unsatisfactorily), other categories also seem to present themselves - in a rather crude, unsystematic fashion; there are views which could be called benign or rosy, others which are based on hearsay, others which seem to be conscious ur unconscious maskings of the real situation. I have not yet attempted to resolve the problems of constructing a water-tight classificatory structure.

All I shall try to do here is to give an initial outline of responses according to hierarchical position:

MM workers have, on the whole, a benevolent view of inter-professional relations; instances are cited of tensions but they are often related to very specific issues - a frequent example is the problem of the elderly and the differences of opinion generated between social work, hospital consultants and GPs about the location of responsibility for particular old people and admissions either to hospital or OPH. Many MM personnel say they do not have a great deal of personal contact with other professionals or agencies; interestingly, the Div. N.O. for a community health division is one of the few respondents who meets many different

professions and is positive about inter-professional relationships - she goes out to solve problems, and finds then solvable.. She also says that she meets regularly with the Community Medicine Specialist and the Sector Administrator and that this produces good results - others at that level within hospital sectors complain because they have no mechanism for joint consultations, and feel this is a tremendous handicap. (Theytalso cite DEG resistance to the idea of local management groups).

Of those MM workers who do complain about other professions, most complain about consultants (both in general and in particular - one psycho-geriatrician, especially). Two Div. NOs complain about problems within nursing - one in a general division discusses conflicts between nurses in different specialties (medicine, surgery, neurosurgery) and another cites the prejudice of nurse teachers towards the chronic sector.

The complaints levelled at consultants are varied - within the health service it is problems about the treatment of patients and their attitudes to ward staff and nursing administration and general (sector) administration. From social work it is mostly problems about interpretation of responsibility for the elderly and admissions to care.

Complaints levelled at other professions are mostly vague instances of boundaries or overlap between health visitors and social workers, OTs and district nurses and hospital social work and community social work./

Amongst those instances cited of good relationships, three suggest that while relationships are good (and have been good since they came into post) this is a new development, and in the past there have been major differences. Of course, there is no way of knowing how far this is correct or how far these are managers believing in the efficacy of their own particular regimes.

Again, amongst these positive instances, there is a feeling that sev several respondents bask in a rather rosy haze of benevolent attitudes towards everything 'out there'. They are concerned with getting on and

doing their job without relating very much to outside concerns, although some recognise that others lower down the scale may meet problems.

Turning to FL workers, we find that inter-professional problems are perceived of as more acute. Basic grade social workers are by far the most articulate and expansive about inter-professional problems. They tend to discuss problems in terms of professional orientation - eg. Health visitors, GPs, consultants do not understand the social work role, or that they have different aims and so on. Health visitors and district nurses, on the other hand, when talking about problems with social workers tend to see the problems in terms of personalities or bad organisational procedures or lack of reciprocity (they always have to do the contracting).

In contrast with MM workers, FL staff give fathmore instances of I-P problems and this does seem characteristic of the front-line where so many different professionals come into direct contact with, or at least shoulder impinging responsibilities for, patients/clients in common.

It is interesting to examine GP responses to the I-P question. Although GPs have been characterised as front-line workers they have proved to offer different responses to many questions when compared to their FL colleagues. This difference persists in this case too. Only one GP gives instances of inter-professional problems (although GPs are often cited by other professionals as creating problems); however, 4 out of 5 GPs, while denying I-P differences, did cite lack of resources (for the elderly, especially).as creating difficulties for themselves. This perhaps points to the self-image of GPs - that they are outside the arena of competing professional interests (- perhaps of higher status?); the problems they perceive are nothing to do with the competing interests of co-equals, but rather of tangible factors such as lack of resources.

It is further evidence that GPs tend to be a maverick profession and that they may need separate handling.

This is by no means an exhaustive review of the inter-professional relationships described by the respondents under scrutiny. It gives a taste, however, of the sorts of problems perceived, and the sorts of distinctions which can be made both between professions, but, especially, between hierarchical levels.

General Conclusion

I have attempted to introduce a new dimension into the analysis of the set of transcripts which I have been working on for the last few months - that of structural position as opposed to professional grouping. While the analysis outlined here is by no means exhaustive, I feel that it has indicated a profitable direction in which to move forward. Undoubtedly in certain instances, the structural cleavages are significant; however, the strength of ideological motivation has been shown to be signfiicant in the case of social workers, and the problem of GPs has yet to be resolved. While the professional/structural dimensions have been here, there are other dimensions which have not yet been considered - some of these may relate to: nature of work done (practitioner/administrator); location of work done (community/institution); location (Glasgow, Elgin, Aberdeen); - and there may be others which have not yet emerged.

By choosing to focus on a limited number of respondents for the last 3 papers, I feel that I have been able to suggest a number of lines of analysis, and to construct various analytical categories which will be of long-term use. I now have to decide whether to continue in this 'pilot fashion' and look for more possible classificatory constructs, or whether I should go full steam ahead and tackle the analysis of the whole number of transcripts and in doing so rely for the guiding principles on the insights gained so far through this pilot technique.

Gillian Dalley. September 1983

Table 1

Instances of Inter-professional differences

FL	Perceived Problems	Neutral View	Good Relations
Health Visitors	4		1
District Nurses	4		1
Bg Social Workers	5		
Ward Sisters	4		
GPs	11		5
	18 (72%)	-	7 (28%)

MM	Perceived Problems	Neutral View	Good Relations
Social W. Admin.			3
Area O. S.W.	22	1	2
Sector Admin.	1	1	2
Div. NO	2	1	1
	5 (29%)	3 (18%)	8 (47%)

TABLE 2. Constraints

	Constraints (% of Total)								
	A Workload	B Staffing Levels	C Industrial Action	D Scarcity of Resources	E Effects of Cuts	F Professional Matters	G Nature of the Work	H Other Agencies	I Structural
Front-Line	18.5	33	7	18.5	4	7	-	4	7
Middle-Management	—	15	11.5	31	11.5	8	8	-	15

Table 3

Community Care

	A All except hospital %	B All except hospital and residential care %	C Own home %
FL	52	32	16
MM	35	35	29

Table 4

Family/State

	A Primarily State %	B Partnership %	C Family and Prof. support %	D Primarily Family %
FL	6	28	36	28
MM	6	12	76	6

Table 5

Public Expectations

	A Expect too little %	B Not expect too much %	C Expect too much %	D Can't generalise or 50/50 %
FL	4	37.5	50	8
MM	-	41	29	29

Table 6

Public Responsibility

	A Yes, are responsible %	B No, not responsible %	C Can't generalise or 50/50 %
FL	26	47	28
MM	46	13	40

Table 7

Government Priorities

	A Agree %	B Disagree %
FL	72	28
MM	76	23.5

Table 8

Sectors to lose

	A None to lose %	B Some (specified) to lose %	C Can't say %
FL	58	29	12.5
MM	47	17.6	35

Table 9

Which Group?

	Elderly %	Mentally ill %	Ment. & Phys. Handicapped %	YCS %	None %	Can't Say %
FL	40	4.5	9	4.5	40	
MM	12.5	-	12.5	6	31	31

Table 10

Re-
Resource Allocation

	Pro Pro %	Sceptical Sceptical %	Not prepared to say, Can't say %
FL	32	56	12
MM	41	47	12

Table 11

Preventions

	More (positive) %		More %	No Change %
FL	(24)	72	(48)	28
MM	(6)	82	(76)	18

Table 12

Waste, economies

	Yes, can improve %	No, can't %	Don't know %
FL	60	17	21
MM	70	29	-

APPENDIX III

Coding index

Respondent Number		1 2 3	
Gender		4	
	Male		01
	Female		02
Location		5	
	Glasgow		01
	Aberdeen		02
	Elgin		03
Agency		6	
	Health		01
	Social Work		02
Profession		7 8	
	Hosp. Doctor		01
	GP		02
	CMS		03
	Gen. Hosp. Nurse		04
	Psych. Hosp. Nurse		05
	Dist. Nurse		06
	Health Visitor		07
	HB Officer (Finance		08
	HB Officer (Admin.)		09
	HB Officer (Doctor)		10
	HB Officer (Nurse)		11
	S.W Fieldworker		12
	S.W. Manager		13
	S.W. Residential, day care worker		14

15
16.

Career Mobility		9	
	Missing		00
	Same Location		01
	Within Scotland		02
	Within UK		03
	Abroad		04
Current Post		10 11	
	Consultant Geriatrician		01
	Psychiatrist		02
	Psych-ger		03
	Orthop		04
	Rheumat		05
	Physician		06
	Gen. Surgeon		07
	Neuro. Surgeon		08
	Other		09
	Single-handed GP		10
	Group practice GP		11
	CMS		12
	CAMO		13
	DMO		14
	CANO		15
	DNO		16
	DV NO		17
	SNO		18
	Ward Sister		19
	Dist. Nurse		20

Current Post (contd.)		10 11	
	HV		21
	HB Sec		22
	DA		23
	Sect A		24
	HB Treas		25
	D Fin. O		26
	Dir. SW		27
	Dep. Dir. SW		28
	SW Manager		29
	Area Officer/Prin. Off. SW		30
	Senior SW		31
	BG SW		32
	SW Admin/Supervisor		33
	RC/DC Officer		34
	Physiother		35
	OT		36
Hierarchy		12	
	Head		01
	Senior		02
	Middle		03
	Sub-Middle		04
	Junior		05
Job-Type (a)		13	
	Administrator		01
	Practitioner		02

Job-Type (b) (eg. Senior SW Ward Sister)	Manager	14	01
	Manager & Managed		02
	Managed		03
Interprofessional relations (consultants)		15	
	Good - Yes		01
	No		02
	Neutral		03
	Na		09
IPR (consultants)		16	
	Overlapping JR		
	Neg.		01
	Pos.		02
	Na		09
IPR (consultants)		17	
	Hierarchy/line management		
	Neg.		01
	Pos.		02
	Na		09
IPR (consultants)		18	
	Prof. orientation		
	Neg.		01
	Pos.		02
	Na		09
IPR (consultants)		19	
	Organisation		
	Neg.		01
	Pos.		02
	Na		09

IPR (consultants)		20	
	Attitudes, sup/inf		
	Neg.		01
	Pos.		02
	Na		09
IPR (consultants)		21	
	Other		
	Neg.		01
	Pos.		02
	Na		09
IPR (GPs)		22	
	Good - Yes		01
	No		02
	Neutral		03
	Na		09
IPR (GPs)		23	
	Overlapping JR		
	Neg.		01
	Pos.		02
	Na		09
IPR (GPs)		24	
	Hierch./line management		
	Neg.		01
	Pos.		02
	Na		09
IPR (GPs)		25	
	Prof. orient.		
	Neg.		01
	Pos.		02
	Na		09

IPR (GPs)		26	
	Organisation		
	Neg.		01
	Pos. Na		02 09
IPR (GPs)		27	
	Attitudes, sup/fin		
	Neg.		01
	Pos. Na		02 09
IPR (GPs)		28	
	Other		
	Neg.		01
	Pos. Na		02 09
IPR (General Nurses)		29	
	Good - Yes		01
	- No		02
	- Neutral Na		03 09
IPR (Gen N)		30	
	Overlapping JR		
	Neg.		01
	Pos. Na		02 09
IPR (Gen N)		31	
	Hierch/line m.		
	Neg.		01
	Pos. Na		02 09

IPR (Gen N)	32	
Prof. Orient.		
Neg.		01
Pos.		02
Na		09
IPR (Gen N)	33	
Org.		
Neg.		01
Pos.		02
Na		09
IPR (Gen N)	34	
Attitudes, s/i		
Neg.		01
Pos.		02
Na		09
IPR (Gen N)	35	
Other		
Neg.		01
Pos.		02
Na		09
IPR (Psych Nurses)	36	
Good - Yes		01
- No		02
- Neutral		03
Na		09
IPR (Psych N)	37	
Overlapping JR		
Neg.		01
Pos.		02
Na		09
IPR (Psych N)	38	
Hierarch/line m		
Neg.		01
Pos.		02
Na		09

IPR (Psych. N)	39	
Prof Orient		
Neg.		01
Pos.		02
Na		09
IPR (Psych. N)	40	
Org.		
Neg.		01
Pos.		02
Na		09
IPR (Psych. N)	41	
Attitude, sup/inf		
Neg.		01
Pos.		02
Na		09
IPR (Psych. N)	42	
Other		
Neg.		01
Pos.		02
Na		09
IPR (Dist Nurses)	43	
Good - Yes		01
No		02
Neutral		03
Na		09
IPR (Dist N)	44	
Overlapping JR		
Neg.		01
Pos.		02
Na		09
IPR (Dist N)	45	
Hierarch/line m.		
Neg.		01
Pos.		02
Na		09

IPR (Dist. N)	46	
Prof. Orient.		
Neg.		01
Pos.		02
Na		09
IPR (Dist N)	47	
Org.		
Neg.		01
Pos.		02
Na		09
IPR (Dist. N)	48	
Attitudes, sup/inf		
Neg.		01
Pos.		02
Na		09
IPR (Dist N)	49	
Other		
Neg.		01
Pos.		02
Na		09
IPR (Health Visitors)	50	
Good - Yes		01
- No		02
- Neutral		03
Na		09
IPR (HV)	51	
Overlapping JR		
Neg.		01
Pos.		02
Na		09
IPR (HV)	52	
Hierarch/line m.		
Neg.		01
Pos.		02
Na		09

IPR (HV)	53	
Prof. Orient.		
Neg.		01
Pos.		02
Na		09
IPR (HV)	54	
Org.		
Neg.		01
Pos.		02
Na		09
IPR (HV)	55	
Attitudes, sup/inf		
Neg.		01
Pos.		02
Na		09
IPR (HV)	56	
Other		
Neg.		01
Pos.		02
Na		09
IPR (Dist HB Off)	57	
Good - Yes		01
- No		02
- Neutral		03
Na		09
IPR (D HB O)	58	
OverlappiNG JR		
Neg.		01
Pos.		02
Na		09
IPR (D HB O)	59	
Hierarch./line m.		
Neg.		01
Pos.		02
Na		09

IPR (D HB O)	60	
Prof. Orient.		
Neg.		01
Pos.		02
Na		09
IPR (D HB O)	61	
Org.		
Neg.		01
Pos.		02
Na		09
IPR (D HB O)	62	
Attitudes, sup/inf		
Neg.		01
Pos.		02
Na		09
IPR (D HB O)	63	
Other		
Neg.		01
Pos.		02
Na		09
IPR (Area HB O)	64	
Good - Yes		01
- No		02
- Neutral		03
Na		09
IPR (Area HB O)	65	
Overlapping JR		
Neg.		01
Pos.		02
Na		09
IPR (A HB O)	66	
Hierarch/line m.		
Neg.		01
Pos.		02
Na		09

IPR (A HB O) Prof. Orient.	67	
Neg.		01
Pos. Na		02 09
IPR (A HB O) Org.	68	
Neg.		01
Pos. Na		02 09
IPR (A HB O) Attitudes, sup/inf	69	
Neg.		01
Pos. Na		02 09
IPR (A HB O) Other	70	
Neg.		01
Pos. Na		02 09
IPR (Field SW) Good - Yes	71	01
- No		02
- Neutral Na		03 09
IPR (Field SW) Overlapping JR	72	
Neg.		01
Pos. Na		02 09
IPR (Field SW) Hierarch/line m.	73	
Neg.		01
Pos. Na		02 09

IPR Field SW		74	
	Prof. Orient.		
	Neg.		01
	Pos.		02
	Na		09
IPR Field SW		75	
	Org.		
	Neg.		01
	Pos.		02
	Na		09
IPR (Field SW)		76	
	Attitudes, sup/inf		
	Neg.		01
	Pos.		02
	Na		09
IPR (Field SW)		77	
	Other		
	Neg.		01
	Pos.		02
	Na		09
IPR (SW Managers)		78	
	Good - Yes		01
	- No		02
	- Neutral		03
	Na		09
IPR (SW Managers)		79	
	Overlapping JR		
	Neg.		01
	Pos.		02
	Na		09
IPR (SW Managers)		80	
	Hierarch/line m		
	Neg.		01
	Pos.		02
	Na		09

IPR (SW Managers)	81	
Prof. Orient.		
Neg.		01
Pos.		02
Na		09
IPR (SW Managers)	82	
Org.		
Neg.		01
Pos.		02
Na		09
IPR (SW Managers)	83.	
Attitudes, sup/inf		
Neg.		01
Pos.		02
Na		09
IPR (SW Managers)	84	
Other		
Neg.		01
Pos.		02
Na		09
IPR (Resid/D Care)	85	
Good - Yes		01
- No		02
- Neutral		03
Na		09
IPR (Resid/D Care)	86	
Overlapping JR		
Neg.		01
Pos.		02
Na		09
IPR (Resid/D Care)	87	
Hierarch/line m.		
Neg.		01
Pos.		02
Na		09

IPR (Resid/DC)	88	
Prof. Orient.		
Neg.		01
Pos.		02
Na		09
IPR (Resid/DC)	89	
Org.		
Neg.		01
Pos.		02
Na		09
IPR (Resid./DC)	90	
Attitudes, sup/inf		
Neg.		01
Pos.		02
Na		09
IPR (Resid./DC)	9	
Other		
Neg.		01
Pos.		02
Na		09
IPR (Other)	9	
Good		01
Bad		02
NC		03
Na		09

Inter Agency Relations (SW)		93	
	Good		01
	Bad		02
	NC Na		03 09
IAR (Nursing)		94	
	Good		01
	Bad		02
	NC Na		03 09
IAR (Medicine)		95	
	Good		01
	Bad		02
	NC Na		03 09

IAR (Housing)		96	
	Good		01
	Bad		02
	NC Na		03 09
IAR (DHSS)		97	
	Good		01
	Bad		02
	NC Na		03 09
IAR (Education)		98	
	Good		01
	Bad		02
	NC Na		03 09
IAR (Health Board)		99	
	Good		01
	Bad		02
	NC Na		03 09
IAR (Other)		100	
	Good		01
	Bad		02
	NC Na		03 09
Policy-Making Process		101	
	Missing		00
	Scope for influencing		01
	Sense of powerlessness		02
	Neutral view		03

Constraints		102	
	Missing		00
	Yes		01
	No		02
	NC		03
	Na		09
Constraints: Workload/ staffing levels		103	
	Yes		01
	No		02
	NC		03
	Na		09
Constraints: Industrial Action		104	
	Yes		01
	No		02
	NC		03
	Na		09
Constraints: Cuts/scarce resources		105	
	Yes		01
	No		02
	NC		03
	Na		09
Constraints: (own) pro- fessional matters		106	
	Yes		01
	No		02
	NC		03
	Na		09
Constraints - Nature of the work		107	
	Yes		01
	No		02
	NC		03
	Na		09

Constraints: Other agencies/ Professions		108	
	Yes		01
	No		02
	NC Na		03 09
Constraints: Structural		109	
	Yes		01
	No		02
	NC Na		03 09
Constraints: Other		110	
	Yes		01
	No		02
	NC Na		03 09
Community Care		111	
	Missing		00
	Everything outside hosp		01
	All except instn/ resid. (incl OPH care)		02
	Own home		03
	Can't define		04
Family/State		112	
	Missing		00
	Primary State		01
	Partnership		02
	Family & prof. support		03
	Primary family		04
	Can't say		05

Voluntary Sector		113	
	Missing		00
	In favour, unconditionally		01
	In favour, conditionally		02
	Neutral		03
	Dubious		04
	No view, can't say		05
Voluntary Sector - in favour		114	
	On principle		01
	Innovative		02
	As supplementary		03
	Other		04
	Na		09
Voluntary Sector - against		115	
	On principle		01
	Dubious of motives		02
	Encroachment		03
	Other		04
	Na		09

Public Expectations		116	
	Missing		00
	They expect too much		01
	Some do/some don't		02
	Can't generalise		03
	Do not expect too much		04
	They expect too little		05
Public Responsibility		117	
	Missing		00
	They do not take enough responsibility		01
	Some do/some don't		02
	Can't generalise		03
	They take responsibility		04
Government Priorities		118	
	Missing		00
	Agree firmly		01
	Agree - but some equivocation		02
	Balance - evenly spread		03
	Disagree		04
			05

Which sector should lose (if agree with gvt. priorities)	119	
Missing		00
Acute Medicine		01
A little from all non-DG sectors		02
Non-medical (eg. defence, education, benefits)		03
Macro-level change (eg. capitalist society)		04
None should lose		05
Can't say/no comment		06
Which dependency group for priority	120	
Missing		00
Single choice		01
Multiple choice		02
Which DG	121	
Elderly (frail and confused)		01
Na		09
	122	
Psycho-geriatric		01
Na		09
	123	
Mentally Ill		01
Na		09
	124	
Mentally handicapped		01
		09

		125	
	Physically Handicapped		01
	Na		09
		126	
	Young Chronic Sick		01
	Na		09
		127	
	None singled out		01
	Na		09
Reallocation of resources		128	
	Missing		00
	Yes		01
	No		02
	Non-committal		03

R of R:	Transfer of resources between services/ agencies	129	
	From NHS: Yes		01
	No		02
	NC Na		03 09
		130	
	From LA: Yes		01
	No		02
	NC Na		03 09
R of R	Transfer from institutions to community	131	
	Yes		01
	No		02
	NC Na		03 09
R of R	All under NHS umberella	132	
	Yes		01
	No		02
	NC Na		03 09
R of R	All LA umberella	133	
	Yes		01
	No		02
	NC Na		03 09
R of R	Greater collaboration between agencies (eg. planning etc)	134	
	Yes		01
	No		02
	NC Na		03 09

R of R	Greater collaboration between professionals	135	
	Yes		01
	No		02
	NC Na		03 09
R of R	Other	136	
	Yes		01
	No Na		02 09
Collaboration		137	
	Missing		00
	Positive views		01
	Sceptical		02
	Hostile		03
	No view, no comment		04
Prevention		138	
	Missing		00
	Positively in favour		01
	Mildly in favour		02
	Sceptical (no change)		03
	Against, or less		04
Types of Prevention	Health education (campaigns etc.)	139	
	Yes		01
	No		02
	NC Na		03 09
Prevention	Technical (eg. screening, genetic counselling	140	
	Yes		01
	No		02
	NC Na		03 09

Prevention	Interventionist (crisis prevention)	141	
	Yes		01
	No		02
	NC Na		03 09
Prevention	Other	142	
	Yes		01
	NC Na		02 09
Cut out waste, better use of resources		143	
	Missing		00
	Possible		01
	Don't know		02
	Impossible		03
Type of Improvements:		144	
	Equipment (savings on)		
	Yes		01
	No		02
	NC Na		03 09
Improvement:	Rationalisation (of serivces and organ-isation)	145	
	Yes		01
	No		02
	NC Na		03 09
Improvements:	Administration (cut top-heavy)	146	
	Yes		01
	No		02
	NC Na		03 09

Improvements	Other	147	
	Yes		01
	NC Na		02 09
Specific Services (introduction or development)		148	
	Health - domiciliary		
	Yes		01
	No		02
	NC Na		03 09
S.S.	Health - community	149	
	Yes		01
	No		02
	NC Na		03 09
S.S.	Health- institutional	150	
	Yes		01
	No		02
	NC Na		03 09
Specific Services	LA - domiciliary	151	
	Yes		01
	No		02
	NC Na		03 09
	LA - community	152	
	Yes		01
	No		02
	NC Na		03 09

	LA - residential	153	
	Yes		01
	No		02
	NC Na		03 09
S.S.	Other	154	
	Yes		01
	No		02
	NC Na		03 09
Policy Statements:	Does the organisation make its policy clear	155	
	Missing		00
	Yes		01
	No		02
	No Comment		03
Policy Statements: (if not clear or no comment)			
	Would clarity be an improvement?	156	
	Missing		00
	Yes		01
	No		02
	No comment/Equivocal Na		03 09

APPENDIX IV

Respondent details

Index of Issues

	Resp. No.	Page No.	Issue No.
Respondent/transcript number			
Blocked beds			1
BASW			2
Chronic/acute			3
Case allocation process			4
Contentious issues (as perceived by respondent)			5
Community/communality-collectivism			6
Discharge			7
District nursing			8
Experience of dependency			9
Family ideology			10
Financial support, need for			11
Fund raising			12
Geriatric nursing/medicine			13
GPs			14
Home Helps			15
Health Board			16
Health visitors			17
Housing department			18
Independence, need for			19
Industrial action			20
Liaison			21
Local facts (relevant to DGs)			22
Nursing homes			23
General nursing			24

	Resp. No.	Page No.	Issue No.
OPHs			25
Organisational structure			26
OTs			27
Orientation (professional)			28
Preferences (personal and others')			29
Proliferation/fragmentation (of services)			30
Priorities			31
Patient care			32
Particular personnel			33
Psycho-geriatrics			34
Psychiatric nursing			35
Personality vs. position			36
Public opinion			37
Resources availability			38
Residential care			39
Sheltered housing			40
Social Work (agency and profession)			41
Team Work			42
Therapeutic Groups			43
Voguish concepts			44
YCS Units			45

APPENDIX V

Variables matrix

Public meeting

Govt priorities

Sector to lose

Whole DG priority

Elderly

Psycho-ge

Ment. Ill

Med. han

Phys. han

YCS

N.S.C

Reall. Hosp

Trans. IRS

From NHS

From LA

Int/comm

All NHS

All LA

Agency collab

Prof collab

R&R Other

C/Hab

APPENDIX VI

Frequency distributions tables

Table I - Family/state responsibility
Table II - Public expectations
Table III - Public responsibility
Table IV - Voluntary sector
Table V - Priority policies
Table VI - Sectors to lose
Table VII - Reallocation of resources
Table VIII - Prevention
Table IX - Better use of resources
Table X - Community care
Table XI - Inter-professional problems

%	Primarily state	Partnership	Family + prof support	Primarily family	Can't say
Consultants	0	33	17	21	29
GPs	0	11	32	47	11
Health Visitors	9	36	36	18	0
District Nurses	0	33	25	42	0
Ward Sisters	6	18	35	29	12
NHS Managers - Area	13	63	25	0	0
- District	0	33	33	20	13
- Middle	0	28	50	17	6
- First line	8	50	0	42	0
Aggregated	4	40	30	21	6
Social Work - Senior	0	100	0	0	0
- Divisional	0	33	67	0	0
- Middle	7	23	27	13	13
Aggregated	4	42	38	8	8
Senior Social Workers	20	10	45	15	10
Basic Grade Soc Workers	10	50	30	7	3

TABLE I. Family/state responsibility

%	Expect too much	Some do/some don't	Can't generalise	NOT too much	Expect too little
Consultants	65	5	0	25	5
GPs	84	0	0	16	0
Health Visitors	73	9	0	9	9
District Nurses	64	0	0	36	0
Ward Sisters	53	0	20	20	7
NHS Managers - Area	40	0	40	20	0
- District	56	11	11	11	11
- Middle	47	18	6	29	0
- First line	44	11	11	22	11
Aggregated	48	13	13	23	3
Social Work - Senior	0	0	0	100	0
- Divisional	57	14	14	0	14
- Middle	50	6	13	31	0
Aggregated	48	8	12	28	4
Senior Social Workers	47	16	11	16	11
Basic Grade Soc Workers	49	0	0	39	11

TABLE II. Public expectations

%	Do NOT take resp	Some do/ some don't	Can't generalise	DO take resp
Consultants	20	15	0	65
GPs	67	17	6	11
Health Visitors	36	27	0	36
District Nurses	55	18	0	27
Ward Sisters	53	20	20	7
NHS Managers - Area	0	0	29	71
- District	30	20	10	40
- Middle	22	44	6	28
- First line	10	20	10	60
Aggregated	18	27	11	44
Social Work - Senior	0	0	0	100
- Divisional	13	13	0	75
- Middle	18	12	6	65
Aggregated	15	11	4	70
Senior Social Workers	13	35	24	24
Basic Grade Soc Workers	9	13	13	65

TABLE III. Public responsibility

%	In favour unconditionally	In favour conditionally	Neutral	Dubious	No view/can't say
Consultants	35	41	6	12	6
GPs	47	42	5	5	0
Health Visitors	58	42	0	0	0
District Nurses	33	58	0	8	0
Ward Sisters	53	33	0	7	7
NHS Managers - Area	0	71	29	0	0
- District	27	53	0	20	0
- Middle	41	41	0	18	0
- First line	8	50	0	42	0
Aggregated	24	51	4	22	0
Social Work - Senior	0	100	0	0	0
- Divisional	0	100	0	0	0
- Middle	47	53	0	0	0
Aggregated	27	73	0	0	0
Senior Social Workers	61	33	0	6	0
Basic Grade Soc Workers	39	58	0	3	0

TABLE IV. ATTITUDES TO VOLUNTARY SECTOR

%	Firm support	Support with equivocation	Balance	Do NOT support	No comment
Consultants	13	50	4	17	17
GPs	37	32	21	11	0
Health Visitors	42	42	17	0	0
District Nurses	67	8	0	8	17
Ward Sisters	31	38	6	19	6
NHS Managers - Area	13	75	13	0	0
- District	42	27	7	14	7
- Middle	26	26	16	16	16
- First line	42	17	17	8	17
Aggregated	33	31	13	11	11
Social Work - Senior	50	0	0	0	50
- Divisional	22	33	0	0	44
- Middle	33	33	0	7	27
Aggregated	31	31	0	4	35
Senior Social Workers	21	42	5	21	11
Basic Grade Soc Workers	59	24	7	7	3

TABLE V. Attitudes to the priority policies

%	Acute sector	Take some from all sectors	From non-medical	Macro-level change	From none	No comment
Consultants	23	0	5	0	32	41
GPs	35	6	6	0	29	24
Health Visitors	33	17	0	0	33	17
District Nurses	0	0	0	0	33	67
Ward Sisters	19	0	12	0	31	37
NHS Managers - Area	63	0	0	0	13	25
- District	29	0	0	0	21	50
- Middle	32	0	0	0	42	26
- First line	45	9	9	0	18	18
Aggregated	38	2	2	0	27	31
Social Work - Senior	50	0	0	0	0	50
- Divisional	29	0	29	0	14	29
- Middle	20	0	27	7	27	20
Aggregated	25	0	25	4	21	25
Senior Social Workers	29	0	0	0	24	47
Basic Grade Soc Workers	19	7	11	0	30	33

TABLE VI. Sectors to lose resources

%	Yes, possible	No, not possible	No comment
Consultants	33	13	54
GPs	47	5	47
Health Visitors	50	33	17
District Nurses	42	8	50
Ward Sisters	44	0	56
NHS Managers - Area	63	0	38
- District	53	0	47
- Middle	58		42
- First line	58		42
Aggregated	57		43
Social Work - Senior	100	0	0
- Divisional	88	0	13
- Middle	47	0	53
Aggregated	62	0	38
Senior Social Workers	55	0	45
Basic Grade Soc Workers	74	3	23

TABLE VII. Reallocation of resources

%	Positive	Mild support	Sceptical	Against
Consultants	24	41	29	6
GPs	28	33	28	11
Health Visitors	67	17	17	0
District Nurses	27	55	18	0
Ward Sisters	25	63	13	0
NHS Managers - Area	29	43	29	0
- District	77	8	16	0
- Middle	42	50	8	0
- First line	50	30	20	0
Aggregated	53	31	17	0
Social Work - Senior	100	0	0	0
- Divisional	56	33	11	0
- Middle	44	44	6	6
Aggregated	50	38	8	4
Senior Social Workers	41	53	6	0
Basic Grade Soc Workers	40	52	8	0

TABLE VIII. Prevention

%	Possible	Don't know	Impossible
Consultants	70	26	4
GPs	72	17	11
Health Visitors	92	8	0
District Nurses	45	27	27
Ward Sisters	93	0	7
NHS Managers - Area	17	50	33
- District	75	8	16
- Middle	46	8	46
- First line	91	0	9
Aggregated	62	12	26
Social Work - Senior	0	0	0
- Divisional	57	14	29
- Middle	62	15	23
Aggregated	60	15	25
Senior Social Workers	69	8	23
Basic Grade Soc Workers	73	18	9

TABLE IX. Better use of resources

%	All outside hospital	Non-institutional (incl, Old Peoples Homes)	Own home	Can't/won't define
Consultants	52	19	19	10
GPs	50	33	17	0
Health Visitors	42	25	33	0
District Nurses	50	17	33	0
Ward Sisters	33	17	44	0
NHS Managers - Area	26	14	26	26
- District	53	13	20	13
- Middle	63	25	13	0
- First line	8	50	42	0
Aggregated	42	26	24	8
Social Work - Senior	100	0	0	0
- Divisional	29	0	29	43
- Middle	7	27	67	0
Aggregated	17	17	52	13
Senior Social Workers	12	53	35	0
Basic Grade Soc Workers	11	64	25	0

TABLE X. Definitions of community care

Problems ranked by numbers reported per profession

	1	2	3
Consultants	Other consultants	Basic grade social workers	GPs
GPs	Basic grade social workers	Consultants	Other GPs
Health Visitors	Basic grade social workers	GPs	Consultants
District Nurses	Basic grade social workers	GPs	
Ward Sisters	Consultants	Other nurses	Managers
NHS Managers - Area - District - Middle - First line Aggregated	Consultants	Health Board officers	GPs
Social Work - Senior - Divisional - Middle Aggregated	Consultants	GPs	Basic grade social workers
Senior Social Workers	GPs	Consultants	Basic grade social workers
Basic Grade Soc Workers	GPs	Consultants	Health Visitors

TABLE XI. Inter-professional problems

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